ACCEPTAble

PRINTED: 10/05/2012 FORM APPROVED OMB NO 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL	ULTIPLE CONSTRUCTION DING		SURVEY PLETED
		445278	B. WIN	G	10	/01/2012
	PROVIDER OR SUPPLIER EWOOD NURSING CE	ENTER, INC		STREET ADDRESS, CITY, STATE, ZIP 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	гѕ	F 00	00	• • • • •	
	An annual recertific on September 24, 2 2012.	cation survey was conducted 2012, through October 1,				
	F-272, F-280, F-323 to complete assessi develop/update care failure to identify proand failure to be adripromote safe smoki	e plans, failure to supervise, oblems and implement a plan, ministered in a manner to ng for six (#9, #34, #53, #58,				
	safe smoking practio serious injury, harm, residents #9, #34, #!	The facility's failure to ensure ces was likely to cause impairment, or death to 53, #58, #80, #81) and idents in the facility who				
1	An extended survey 1, 2012.	was completed on October				
V S		od the Director of Nursing Immediate Jeopardy on , at 4:00 p.m., in the				
S F w v	September 22, 2012, Substandard Quality (323-K. An acceptab (hich removed the in (as received and cor	ardy was effective from through October 1, 2012. of Care was cited under le Allegation of Compliance, nmediacy of the jeopardy, rective actions were ne survey team on October				
F:	272 continues at .s	e Immediate Jeopardy tag scope and severity level "D" USUPPLIER REPRESENTATIVE'S SIGNAL				X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445278	B. WING _		10/01/2012	
	PROVIDER OR SUPPLIER	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322	,	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157 SS=D	Continued From parand non compliance tags F280, F323, F4 scope and severity corrective actions a quality assessment. The facility is require correction for all cite 483.10(b)(11) NOTI (INJURY/DECLINE) A facility must immed consult with the resident involving the injury and has the printervention; a significantly (i.e., a mexisting form of treat consequences, or to treatment); or a decithe resident from the §483.12(a). The facility must also and, if known, the reor interested family rehange in room or reconsequences.	ge 1 e of the Immediate Jeopardy 190, and F520 continues at a of a "E" level for monitoring of nd evaluation by the facility's and assurance committee. ed to submit a plan of ed deficiencies. FY OF CHANGES ROOM, ETC) diately inform the resident; dent's physician; and if sident's legal representative elly member when there is an er resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial arreatening conditions or s); a need to alter treatment eed to discontinue an timent due to adverse commence a new form of sion to transfer or discharge e facility as specified in of promptly notify the resident sident's legal representative member when there is a commate assignment as	F 000	This plan of correction is our creallegation of compliance. "Preparation and/or execution of correction does not constitute admission or agreement by the profession of the truth of the facts alleged of deficiencies. The plan of correct prepared and or executed solely because it is required by the profession of federal and state law." F-157- What corrective action(s) will be accomplished for those residents to have been affected by the alledeficient practice? 1. The physician was notified 9/27/12 by DON of the work loss for resident #38 who experienced a slow, steam weight loss over several that did not trigger as a significant weight loss who weights were calculated facility CDM.	dible of orovider or ion is visions s found or eged ed on veight or had dy, months men the by the	
	specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.			 MD was notified by DON weight loss 9/27/12 and that with patient's extent dementia the weight loss 	stated t of	

Facility ID: TN6101

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445278	B. WII	NG_		10/01/2012		
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322				
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	The facility must red the address and philegal representative. This REQUIREMENT by: Based on medical redility policy review failed to notify the plass for one resident recommendation for forty-three residents. The findings include Resident #38 was a 18, 2012, with diagn Senile Delusions, Hy Bronchitis. Medical record revied Data Set dated July resident had short a problems, had sever and required limited. Medical record revied revealed the resident hospital on August 17 facility on August 17 Medical record revied Summary dated Augresident was treated antibiotics and nebul Dementia with Bibas	cord and periodically update one number of the resident's or interested family member. IT is not met as evidenced record review, observation, and interview, the facility hysician of a significant weight t (#38), and of a psychiatric rone resident (#17) of reviewed. Id: Idmitted to the facility on April revealed the moses including Dementia, expertension, and Acute rely impaired cognitive skills, assistance with eating. In of the nursing notes the was transferred to the 4, 2012, and returned to the 2012. In of a hospital Discharge revealed the end of a hospital Discharge resident's according to the end of a hospital Discharge revealed the end of a hospital Discharge revealed the end of the end of a hospital Discharge revealed the end of the end of a hospital Discharge revealed the end of the end of a hospital Discharge revealed the end of the	F	157	be expected and wished intervene at present time 3. The physician was notifie 9/27/12 by the DON, of the psychiatric consult recommendation for medication adjustments for resident #17. 4. The physician has agreed to recommendation and an example of the ME medication adjustment. How will you identify other reside having the potential to be affected the same alleged practice(s) and we corrective action will be taken? 1. All current medical record were audited by the DON ADON on 9/28/12, to ensure the potential on the medical record prior to orders being written following MD appears for recommendation. The reviewed weights of all residents and provided the DON with a list of all residents and the New York and Yor	d on the for to the porder of for the the porder of for the porder		

Facility ID: TN6101

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	June 4, 2012, 145 p and 136.6 pounds of loss of 8.4 pounds of 2012, and a loss of June 4, 2012). Medical record reviet the physician was not loss. Review of the facility Standards revealed weight variance will utilizing the following 5%six months 10% more gain or loss in and the Dining Servithe Nursing Departn Observation on Sep p.m., revealed the re restorative dining tal Continued observati consumed a grilled of approximately 1/2 of of slaw, approximate approximately 130 m and 100% of the Boo Interview on Septem	on tweighed 156.4 pounds on abounds on August 17, 2012, an September 18, 2012, (a pr 5.79% since August 17, 19.8 pounds or 12.65% since aw revealed no documentation of the resident's weight are valuated for significance guidelinesone month and undesired be evaluated for significance guidelinesone month and there is an actual 5% or one month, thephysician ices Director are notified by ment" Itember 27, 2012, at 12:15 asident seated at the ole in the dining room. on revealed the resident had cheese sandwich, a barbeque sandwich, a barbeque sandwich, a barbeque sandwich, and (milliliters) of whole milk, ost (nutritional supplement).	F 15	was notified on 10/6	nto place or ou make to ient cur? rector will petting the cions to the received land land land land land land land lan		
	revealed the residen day since admission three times a day.	etary Manager in the lobby t had received Boost twice a to the facility and snacks		family notifications o 10/08/12 by the DON How will the corrective action			
		ber 27, 2012, at 12:30 p.m., lursing (DON), in the DON's		monitored to ensure the alleg		11/15/12	

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NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, INC (X4) ID (X4) ID (X4) ID (X4) ID (X5) ID (X5) ID (X6)		FOF DEFICIENCIES OF CORRECTION						
BROOKEWOOD NURSING CENTER, INC 332 RIVER ROAD DECATUR, TN 37322			445278	B. WII	۱G_		10/0	1/2012
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 4 office, confirmed the physician had not been notified of the resident's significant weight loss. Telephone interview on September 27, 2012, at 2:05 p.m., with the physician revealed the resident had Advanced Dementia and it was not unusual for residents with Advanced Dementia to start eating less. Continued interview revealed if the physician had been notified of the resident's weight loss, no additional orders would have been given to the nursing staff. Resident #17 was admitted to the facility on June 13, 2011, with diagnoses including Alzheimer's Disease, Depressive Disorder, Anxiety State, Chest Pain, Anemia, Hypertension, Hearing Loss, Coronary Artery Disease, Gastro-Esophageal Reflux, Chronic Obstructive Pulmonary Disease, and Psychosis. Medical record review of a psychiatric consult dated August 5, 2012, revealed the resident was paranoid, anxious, depressed, was alert and had poor judgment. Continued review of the psychiatric consult revealed a recommendation to reduce Geodon (antipsychotic) to 40 mg (milligrams) for three days at 8:00 p.m., then 20 mg for 2 days, then stopand to increase the Depakote (mood stabilizer) to 250 mg twice a day. Medical record review of the August 2012,			NTER, INC	332 RIVER ROAD				
office, confirmed the physician had not been notified of the resident's significant weight loss. Telephone interview on September 27, 2012, at 2:05 p.m., with the physician revealed the resident had Advanced Dementia and it was not unusual for residents with Advanced Dementia to start eating less. Continued interview revealed if the physician had been notified of the resident's weight loss, no additional orders would have been given to the nursing staff. Resident #17 was admitted to the facility on June 13, 2011, with diagnoses including Alzheimer's Disease, Depressive Disorder, Anxiety State, Chest Pain, Anemia, Hypertension, Hearing Loss, Coronary Artery Disease, Gastro-Esophageal Reflux, Chronic Obstructive Pulmonary Disease, and Psychosis. Medical record review of a psychiatric consult dated August 5, 2012, revealed the resident was paranoid, anxious, depressed, was alert and had poor judgment. Continued review of the psychiatric consult revealed a recommendation to reduce Geodon (antipsychotic) to 40 mg (milligrams) for three days at 8:00 p.m., then 20 mg for 2 days, then stopand to increase the Depakote (mood stabilizer) to 250 mg twice a day. Medical record review of the August 2012,	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
receive Geodon (antipsychotic medication) 60 mg (milligrams) every evening, and Depakote 125 mg twice daily. Medical record review of the August 2012, and		office, confirmed the notified of the resident notified of the resident 2:05 p.m., with the president had Advanuated for resident start eating less. Conthe physician had be weight loss, no addingvent to the nursing Resident #17 was a 13, 2011, with diagrous Disease, Depressive Chest Pain, Anemia Coronary Artery Dis Reflux, Chronic Obsand Psychosis. Medical record revied ated August 5, 201 paranoid, anxious, copor judgment. Corpsychiatric consult reduce Geodon (and (milligrams) for three mg for 2 days, then Depakote (mood staday). Medical record revied physician's orders rereceive Geodon (and (milligrams) every entwice daily.	e physician had not been ent's significant weight loss. y on September 27, 2012, at ohysician revealed the ced Dementia and it was not its with Advanced Dementia to ontinued interview revealed if een notified of the resident's itional orders would have been staff. Idmitted to the facility on June noses including Alzheimer's e Disorder, Anxiety State, a, Hypertension, Hearing Loss, rease, Gastro-Esophageal structive Pulmonary Disease, ew of a psychiatric consult 12, revealed the resident was depressed, was alert and had natioued review of the evealed a recommendation to tipsychotic) to 40 mg e days at 8:00 p.m., then 20 stopand to increase the abilizer) to 250 mg twice a lew of the August 2012, evealed the resident was to tipsychotic medication) 60 mg evening, and Depakote 125 mg	F	157	what quality assurance progra put into place? 1. DON or ADON will rep compliance with notifi the QA Committee for	m will be ort on cations to 3	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN6101

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		[` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445278 B. WING		· · · · · · · · · · · · · · · · · · ·	10/01/2012			
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		332 RIVE	DRESS, CITY, STATE, ZIP CODE RR ROAD JR, TN 37322			
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SS=J	September 1-25, 20 revealed the resider 125 mg twice daily a evening. Medical record reviet the physician was not decrease the Geodepakote. Observation on September 1 decrease the Geodepakote of the bed feeding self of the bed feeding self of the psychiatric record 2012, to decrease the psychiatric record 2012, to decrea	and Geodon 60 mg every ew revealed no documentation otified of the recommendation odon and increase the seident sitting on the side of breakfast. The 25, 2012, at 3:18 p.m., Nursing, in the conference physician was not notified of mmendation dated August 5, are Geodon and increase the REHENSIVE	F 1	F 27 The com resid	facility conducts initial and prehensive, accurate, stand oducible assessments of eatlent's functional capacity. It corrective action(s) will be implished for those residentieve been affected by the all cient practice? The smoking assessment residents #58, #81, #80 completed on 9/27/12 to MDS Coordinator.	dardized ch e ts found eged ats for were		

	The state of the s	A MEDIONID SERVICES				OINP NO	<u>. 0938-0391</u>
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		IPLE CONSTRUCTION	(X3) DATE S	
		445278	B, WII	B, WING		10/01/2012	
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		·
BROOK	(EWOOD NURSING CE	INTER, INC	!	Э	32 RIVER ROAD DECATUR, TN 37322		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION	1 200
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 272	Continued From pa	ge 6	F2	272	How will you identify other res	idents	
	Mood and behavior	patterns;			having the potential to be affect	ted by	í (
	Psychosocial well-b				the same alleged practice(s) an	d what	
	Continence:	and structural problems;		ĺ	corrective action will be taken?	i	
		and health conditions;			Updated smoking asses	sments	
	Skin conditions;				were completed for all		ŀ
	Activity pursuit;				residents who smoke o		
Medications; Special treatments a Discharge potential; Documentation of si		and procedures:			9/27/12 by the MDS		
		ımmary information regarding			Coordinator, DON and	ADON.	
	the additional assess	sment performed on the care the completion of the Minimum			What measures will be put into	place or	
	Data Set (MDS); and	ie completion of the Minimum			what systematic changes will yo	u make	
	Documentation of pa	articipation in assessment.			to ensure that the alleged defici	ient	
					practice(s) does not reoccur?		
					1. Smoking Assessments for	all	
					residents who smoke will	be	-
					completed at admission b	y the	i
i	This REQUIREMENT	T is not met as evidenced			admitting charge nurse, a	nď i	
	by:				reviewed by the MDS		
	the facility failed to as	ecord review and interview ssess the smoking habits of			Coordinator, with schedul	ed	
	three residents (#58,	#81, #80) of nineteen			RAI assessments, and as n	eeded	
	residents reviewed for	or smoking.			based on a change in cond	lition.	1
	The facility's failure p	loced the residents in			The MDS coordinator will		1
į	Immediate Jeopardy	(a situation in which a			monitor for completion of	:	ļ
ľ	provider's noncomplia	ance with one or more			admission smoking assessi	ments	į
İ	requirements of partic	cipation has caused, or is		.	for all new admissions for	з	ľ
	likely to cause serious harm, injury, impairment or death from unsafe smoking).				months beginning in Octob	jer,	
1					and complete updates as		
	The Nursing Home A	dministrator (NHA) and the			indicated on an on-going b	asis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445278	B. WING			10/01/2012	
	ROVIDER OR SUPPLIER WOOD NURSING CE	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 132 RIVER ROAD DECATUR, TN 37322		
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The state of the s	Immediate Jeopard, 4:00 p.m., in the cor 4:00 p.m., in the cor 4:00 p.m., in the cor The findings include Resident #58 was a September 14, 2012 Pneumonia, Chronic Dementia with Beha Fibrillation, Hyperter Disorder. Review of the list of facility as smokers, active smoker. Mediasessed for safe significant with Licensed Practionarse's station, confirmed Practionarse's station, confirmed resident #60 ponitional facility with the Diametria for safe smoking. Resident #81 was acceptember 12, 2012 Right Hip Fracture, Licensed Practure, Licensed	(DON) were notified of the y on September 26, 2012, at inference room. ed: dmitted to the facility on 2, with diagnoses including 3 Airway Obstruction, avior, Gouty Arthritis, Atrial insion, and Depressive residents identified by the revealed resident #58 was an lical record review revealed in resident had been moking. aber 26, 2012, at 1:57 p.m., cal Nurse (LPN) #3 at the irmed resident #58 smoked ing designated smoking rector Of Nursing (DON) in Sept. 26, 2012, at 2:15 p.m., 158 had not been assessed dmitted to the facility on the with diagnoses including Urinary Tract Infection,	Fi	272	How will the corrective action(s) be monitored to ensure the alleged deficing practice(s) will not reoccurrently assurance provided the put into place? 1. Compliance with maintate accurate, complete smole assessments as monitored MDS Coordinator will be reported to the QA Complete to the QA Complete in Director, Certified Dietar Manager, Maintenance Supervisor, Business Offit Manager, Housekeeping Supervisor, Restorative Monthly x 3 months, begin October.	ent ur; program ining king ed by mittee ON, Service y ce	10/01/12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		33	EET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD ECATUR, TN 37322	f	
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F 272	answers on the Brie assessment (BIMS functioning where a severe cognitive im revealed the resider assistance with transpigene. Review of the list of facility as smokers, active smoker. Medical record revies moking Evaluation was a two the reverse side of completed leaving the resident's ability to sufficient with the A (ADON) in the Directon September 26, 2 the Safe Smoking Evaluation was not compresident's ability to sufficient was not compresident was not compresident's ability to sufficient was not compresident was not compressed ability to sufficient was not compressed ability to sufficient wa	of Interview for Mental Status - an assessment for cognitive score of 1 to 7 indicates pairment.) Continued review int required extensive exfers, eating, and personal residents identified by the revealed resident #81 was an ew of the resident's Safe in (undated) revealed the ro-sided assessment form and the assessment had not been the final determination of the smoke safely unanswered. ssistant Director of Nursing ctor Of Nursing (DON) office 2012, at 2:30 p.m., confirmed evaluation in the medical inplete and did not identify the smoke safely. idmitted to the facility on ith diagnoses including ion, Failure to Thrive, Muscle	F	272			

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F 272	extensive assistance personal hygiene, a help only at mealtim. Review of the list of facility as smokers, active smoker. Medical record reviet assessment titled, Stated August 13, 20 was a two-sided assistered assistered as reverse side of the accompleted, leaving resident's ability to suffice, confirmed the assessed for safe suffice, confirmed the assessed for safe suffice, confirmed the assessed for safe suffice, and was removed of acceptable Allegation received and correct on-site by the surveithrough review of faresident interviews, team verified the allegation reassessed for verifying the other refacility had accurate	residents identified by the revealed resident's smoking Safe Smoking Evaluation, D12, revealed the evaluation sessment form, and the assessment had not been the final determination of the smoke safely unanswered. ssistant Director of Nursing on 2, at 2:30 p.m., in the DON's eresident had not been moking. pardy was effective from 2 through October 1, 2012; in October 1, 2012; in October 1, 2012, on of Compliance, which liacy of the Jeopardy, was tive actions were validated by team on October 1, 2012, cility documents, staff and and observations. The survey egation of compliance by: ints #80, #81, and #58, had in smoking safety; and esidents who smoke at the smoking assessments. Exing assessments was	F:	272			

Event ID: 216H11

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 272	observation during 2. Verifying reside and #9 had been expressed smoking pothe information on its eptember 26, 201 team verified the inthrough observation 27, 2012, and intervary, 2012, and intervary, 2012, at 10:30 at 3. Verifying the repolicy with acknowleand agreement to the ensure a safe smokresidents. 4. Verification by the 2012, ensured by instaff, and review of staff received information to ensure that a returned and locked and that cigarette bin the locked, metal smoke break. Residencing are to ensure that a returned and locked and that cigarette bin the locked, metal smoke break. Residencing are to ensure that a returned and locked and that cigarette bin the locked, metal smoke break. Residencing are to ensure that a returned and locked and that cigarette bin the locked, metal smoke break. Residencing be issued a 30 day documentation confamilies of the smoking the revised smoking the revised smoking the smokensure of the sm	smoking sessions. Ints #34, #53, #81, #80, #58, ducated on the facility's dicy. The survey team verified interview with resident #58 on 2, at 4:00 p.m. The survey formation with resident #53 in and interview on September view with #80 on September view with #80 on September a.m. Vision of the facility's smoking edgement of understanding the policy by the residents to king environment for all the survey team on October 1, interviews with multidisciplinary inservice logs confirmed the nation regarding the facility's licy including staff members are the up in the medication room, utts are collected and placed containers following each dents who are found with the interior in their possession will discharge notice. Review of firmed the residents and king residents were notified of	F.2	272			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445278	B. WING			10/01/2012	
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DULD BE	(X5) COMPLETION DATE
F 272	Interview with the D 2012, at 12:50 p.m. Quality Assurance of Administrator, Direct Director of Nursing, Activity Director, Bu Medical Records, M Certified Dietary Ma Supervisor) had me formulate a plan rel smoking and to dev safety. Continued i members of the Qu had revised the faci inserviced the resid revised Smoking Porevealed Social Ser mailed letters to the smoked, informing to Policy. Continued in Medical Director ha	ge 11 Director of Nursing October 1, revealed members of the committee (including the ctor of Nursing, Assistant Social Services Director, siness Office Manager, flaintenance Supervisor, anager, and Housekeeping et on September 28, 2012, to ated to noncompliance with relop a plan to ensure resident interview revealed the ality Assurance committee lity's Smoking Policy, and ents and staff regarding the olicy. Continued interview vices had contacted and families of the residents who them of the facility's Smoking interview revealed the facility's d been made aware of the y on September 28, 2012.	F:	272			
:	monitoring corrective the facility's Quality Committee.	e continues at a "D" level for e actions and evaluation by Assessment and Assurance quired to submit a plan of					
	correction for all cite						
				70	F-279		
	483.20(d), 483.20(k COMPREHENSIVE		F 2	79	The facility develops compre care plans for each resident		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		445278	B. WING _		10/01/2012
	ROVIDER OR SUPPLIER	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 279	to develop, review a comprehensive plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any side to the resident.	the results of the assessment and revise the resident's of care. Evelop a comprehensive care ent that includes measurable tables to meet a resident's of mental and psychosocial tified in the comprehensive of describe the services that are train or maintain the resident's physical, mental, and eing as required under ervices that would otherwise exercise of rights under the right to refuse treatment	F 279	includes measurable objectives time tables to meet the resider medical, nursing, and mental a psychosocial needs that are ide the comprehensive assessment. What corrective action(s) will be accomplished for those resident to have been affected by the all deficient practice? 1. Resident #69 has had he plan updated on 10/11 the MDS Coordinator to monitoring for her hypothyroidism and the medication.	nt's nd entified in ts. ne nts found deged der care 1/12 by o include
	by: Based on medical review, and intervie the comprehensive #69 for monitoring or resident #35 for pre forty-three residents The findings include Resident #69 was a and readmitted on I diagnoses including Convulsions, Hyper			2. Resident #35 care plan Risk for Pressure Ulcer Development. The pres ulcer present upon adm has been resolved. How will you identify other resi having the potential to be affect the same alleged practice(s) an corrective action will be taken? 1. All current medical reco were reviewed by the M Coordinator on 10/11/	idents ited by d what

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445278	B. WII	NG _		10/0	1/2012	
	ROVIDER OR SUPPLIER	NTER, INC	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 279	Dementia without B Disorder, Diabetes, Medical record revidated September 1 Levothyroxine Sodii mcg (microgram) ta Medical record reviorders (undated) signeyealed, TSH (Thy (every) 6 months. (review revealed the completed on Februspan). Medical record revidated August 28, 20 resident's diagnosis had been addressed interview with the M (MDS) on October MDS office, confirm addressed on the resident #35 was readily and the modern and the resident with Psychypertension, Hypo Fractured Left Hip, and Medical record review Ulcer Record dated resident was admitted.	ehaviors, Depressive and Hypothyroidism. ew of the Physician's Orders, 2012, revealed, um (thyroid medication) 25 ablet 1 by mouth every day. ew of the resident's standing gned by the physician, roid Stimulating Hormone) quantity of the physician, roid Stimulating Hormone) quantity 21, 2012 (a seven month ew of the resident's care plantity of the resident's care plantity of the physician of the physician of the resident's care plantity of the TSH had not been esident's care plantity of the TSH had not been esident's care plantity of the physician of the plantity of the teather than the plantity of the teather than the plantity of the plantity of the teather than the plantity of the plantity	F	279	identify any residents thyroid disorders and treated with thyroid medications to ensure plan of care covered to services being provide these residents. 2. The Treatment nurse the medical records for residents with pressure and at risk for pressure development on 10/1 additional residents with pressure of the residents will be put into what systemic changes wil	/or being e that the he ed to reviewed or re ulcers, ee ulcer 1/12; no rere found d to the ulcers or of illed to be of Care. o place or u make to ent ur? was in- by the of olan to s and d to the		

CLIVIE	ING I ON MILDIONING	A MEDIO NO OCI (VIOLO		····	T	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		445278	B. WING _		10/0	1/2012
	PROVIDER OR SUPPLIER	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 279	Dementia without B Disorder, Diabetes, Medical record revidated September 1 Levothyroxine Sodimcg (microgram) to Medical record reviorders (undated) signeyealed, TSH (Thy (every) 6 months. (review revealed the completed on Februspan). Medical record revidated August 28, 20 resident's diagnosis had been addressed Interview with the M (MDS) on October 1 MDS office, confirm addressed on the reactive with Psychypertension, Hypo Fractured Left Hip, and Medical record review Ulcer Record dated	ew of the Physician's Orders, 2012, revealed, um (thyroid medication) 25 ablet 1 by mouth every day. ew of the resident's standing gned by the physician, roid Stimulating Hormone) quantinued medical record most recent TSH was uary 21, 2012 (a seven month ew of the resident's care plantology and the physician of Hypothyroidism duary 21, 2012 (a seven month ew of the resident's care plantology and the physician of Hypothyroidism duary 21, 2012, at 11:22 a.m., in the ed the TSH had not been esident's care plantology and the plantology and the plantology and the plantology and the plantology and osteoporosis. Ew of the Weekly Pressure August 7, 2012, revealed the ed with a Stage II (partial)	F 279	be in-serviced by the D 10/23/12, on the Interi Care addressing pressure u development on admir How will the corrective action monitored to ensure the allege deficient practice(s) will not re what quality assurance progra put into place? 1. The DON &/or ADON reviewed all current c and will review 3 care weekly to monitor for compliance and repor findings to the QA con 3 months, beginning in	m Plan of ire ulcers icer ision. s) be ed occur; m will be are plans plans t the mmittee x	11/15/12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	!	445278	B. WING	<u></u>	10/01/2012
	PROVIDER OR SUPPLIER	INTER, INC		TREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ONTO BE COMPERION
F 279	Medical record revicare plan dated Augare plan dated Augacere plan	ew of the resident's interim gust 7, 2012, and the initial gust 16, 2012, revealed no pressure ulcer had been e plan. ty's Pressure Ulcer Policy, n care plan is to be completed Director of Nursing (DON) on 2, at 3:15 p.m., in the onfirmed the interim care plan plan had not addressed the	F 279	,	
F 280 SS=K	The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive comprehensive assinterdisciplinary teal physician, a register for the resident, and disciplines as determined.	ANNING CARE-REVISE CP ne right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 280	The facility reviews and revises resident's care plans periodica indicated. What corrective action(s) will I accomplished for those resident to have been affected by the adeficient practice? 1. Resident's #53, #9, #34 care plans have been upon safe smoking intervion 9/29/12 by the ADO	be nts found alleged 4, #58 updated ventions

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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	ROVIDER OR SUPPLIER		-1	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	IVLD BE	(XS) COMPLETION DATE
F 280		ge 15 ; and periodically reviewed am of qualified persons after	F	280	Resident #55's care pla updated on 9/25/12 b MDS Coordinator, to in her UTI, and updated v resolution.	y the nclude vith	
	This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to update the care plan for four residents (#53, #9, #34 #58) for safe smoking interventions and for one resident (#55) for a urinary tract infection of forty-three residents reviewed.			How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken? 1. All current smoking residents care plans have been reviewed			
	The facility's failure placed resident #53, #9, #34, and #58 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death) from unsafe smoking. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the Immediate Jeopardy on September 26, 2012, at				and updated as needed to include safe smoking interventions and incorpore revised smoking policy interventions by the MDS Coordinator and ADON of 9/29/12. All new admissions with smoking history will care plans to include the	orated n ions have	
	August 20, 2010, wi Dementia with Beha Depressive Disorde Medical record revide Data Set dated Aug			What measures will be put into place what systematic changes will you mate to ensure that the alleged deficient practice(s) does/do not reoccur? 1. The MDS coordinator was inserviced by the DON on 10/15/12, on care plan update		place or ou make ient ? vas in-	
	67/02-00\ Previous Versions	Obsolete Event ID: 216H11		l	cility ID: TN6101 If contin	vation sheet F	Page 16 of 64

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		445278	B. WIN	≀G		10/0	1/2012
	ROVIDER OR SUPPLIER	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	determine cognitive indicating cognitive with ambulation. Medical record revir Assessment for Sm 2012, revealed "S supervisionSmok tobacco products tobacco products tobacco products Medical record revir August 10, 2012, re (related to) smoking requires supervision smoking policy" Medical record revir February 17, 2012, nurse was on lunch CNA. (certified nurs came out to smoke a favor?" This nurse permit you to smoke a favor?" This nurse permit you to smoke smoke time."This into facility (and) revisible. This nurse res. digging in stand the top (and) was b (cigarettes) that we informed that it was return to(room)I bent over going throbuttstold once against the standard once aga	BIMS-an assessment to abilities with a score of 13-15 by intact and was independent	F	280	and will continue to review hour reports and physicorders for needed care updates, and complete to care plans as indicated. How will the corrective action (monitored to ensure the allege deficient practice(s) will not rewhat quality assurance program put into place? 1. The DON &/or ADON will care plans/week to monitic compliance X3 months at the findings to the QA confor 3 months, beginning in	cian plan updates ed. (s) be ed occur; m will be review 3 or for und report nmittee	11/15/12

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		 _	445278		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	332 RIVER ROAD		INTER, INC		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XI PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XI COMPLETED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X2) ID PROVIDER'S PLAN OF CORRECTION (XI COMPLETED TO THE APPROPRIATE DATE DEFICIENCY)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
Medical record review of a daily skilled nurse's note dated April 18, 2012, revealed "Resident went outback outside. When nurse went to see what resident was doing (resident #53) had a lit cliqarette. Resident instructed to throw away clg. Resident then came inside cussing at staff. Resident asked to give nurse lighter. Resident refused then was told administrator would be call. Resident was told administrator would be call. Resident then brought lighter up to nurses" Review of the facility policy (undated) revealed, "The following smoking policy and agreement is designated to respect the rights and ensure the safety of our residents. This agreement will be explained to residents and/or responsible parties on admission and as neededFacility will keep cigarettes and lighters for residents for whom supervised smoking has been deemed necessary. They will be kept in an area which is accessible to staff onlySmoking on the premises will be limited to the scheduled times and scheduled areas, unless the resident is accompanied by their responsible parties or visitorsThree episodes of non compliance to the smoking policy will result in suspension of smoking privileges for a specified time" Observation on September 26, 2012, at 7:50 a.m., revealed resident #53 obtained a cigarette butt from the smokers ash bin outside in the smoking area. Continued observation revealed no staff present in the smoking area. Observation and interview on September 26, 2012, at 7:55 a.m., with the NHA and the DON,			ew of a daily skilled nurse's 2012, revealed "Resident de. When nurse went to see doing (resident #53) had a lit instructed to throw away cig. e inside cussing at staff. give nurse lighter. Resident old administrator would be call. ght lighter up to nurses" y policy (undated) revealed, " oking policy and agreement is ect the rights and ensure the ints. This agreement will be ints and/or responsible parties as neededFacility will keep ers for residents for whom in has been deemed if he kept in an area which is onlySmoking on the ited to the scheduled times as, unless the resident is eit responsible parties or odes of non compliance to the result in suspension of for a specified time" Intermber 26, 2012, at 7:50 lent #53 obtained a cigarette ers ash bin outside in the inued observation revealed ing the cigarette. Continued d no staff present in the erview on September 26,	Medical record revinote dated April 18, went outback outside what resident was origarette. Resident Resident then came Resident asked to grefused then was to Resident then brown Review of the facilitisThe following smedesignated to reside explained to reside explained to reside on admission and a cigarettes and lights supervised smoking necessary. They will accessible to staff or premises will be liminand scheduled area accompanied by the visitorsThree epis smoking policy will smoking privileges. Observation on Sega.m., revealed resident #53 smoking between the smoking area. Contresident #53 smoking area. Observation and interested the smoking area.	F 280

NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, INC CALL D.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
PROOKEWOOD NURSING CENTER, INC 332 RIVER ROAD DECATUR, TN 37322			445278	B. WII	4G		10/01	1/2012
FREEIV TAG FOR CROSS-REFERENCE TO THE APPROPRIATE DATE FOR CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) FOR CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY FOR CROSS-REFERENCE THE TAKE TO THE APPROPRIATE DEFICIENCY FOR CROSS-REFERENCE TO THE APPROPER TO THE APPROPRIATE DEFICIENCY FOR CROSS-REFERENCE TO THE APPROPER TO THE APP			ENTER, INC		3	32 RIVER ROAD DECATUR, TN 37322		
outside in the smoking area, revealed the DON had obtained a lighter from resident #53. Interview on September 26, 2012, at 11:40 a.m., in the hall, with Licensed Practical Nurse (LPN) #2, confirmed was not aware of all the residents who smoked. Interview on September 26, 2012, at 1:50 p.m., in the hall, with LPN #3, confirmed was not aware of all the residents who smoked. Interview on September 27, 2012, at 1:10 p.m., with the DON, in the conference room, confirmed no investigations had been completed to determine how resident #53 had obtained a lighter on April 18, 2012. Interview on September 27, 2012, at 1:55 p.m., with the NHA, in the conference room, confirmed the NHA was aware of resident #33's unsupervised smoking incident on February 17, 2012. Interview on October 1, 2012, at 10:30 a.m., at the nursing station, with the NHA, confirmed the NHA had a meeting with resident #53 when became aware of the resident smoking unsupervised on February 17, 2012, but had no documentation of the meeting. Interview on October 1, 2012, with the DON, in the hall confirmed the care plan dated August 10, 2012, had not been updated to include the resident's noncompliance with supervised smoking unsupervised had a lighter in their	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	
	F 280	outside in the smok had obtained a light Interview on Septer in the hall, with Lice #2, confirmed was who smoked. Interview on Septer the hall, with LPN # all the residents who Interview on Septer with the DON, in the no investigations had termine how resilighter on April 18, Interview on Septer with the NHA, in the NHA was award unsupervised smol 2012. Interview on Octob the nursing station, NHA had a meeting became aware of the unsupervised on Fedocumentation of the Interview on Octob the hall confirmed 2012, had not beer resident's noncompany smoking or that the	ting area, revealed the DON ter from resident #53. mber 26, 2012, at 11:40 a.m., ensed Practical Nurse (LPN) not aware of all the residents mber 26, 2012, at 1:50 p.m., in f3, confirmed was not aware of no smoked. mber 27, 2012, at 1:10 p.m., e conference room, confirmed ad been completed to ident #53 had obtained a 2012. mber 27, 2012, at 1:55 p.m., e conference room, confirmed e of resident #53's king incident on February 17, er 1, 2012, at 10:30 a.m., at with the NHA, confirmed the g with resident #53 when he resident smoking ebruary 17, 2012, but had no he meeting. er 1, 2012, with the DON, in the care plan dated August 10, in updated to include the pliance with supervised	F	280			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			_	(X3) DATE SURVEY COMPLETED	
		445278	B. WIN	IG		10/0	1/2012
	ROVIDER OR SUPPLIER	NTER, INC	•	STREET ADDRESS, CITY, STATE, ZI 332 RIVER ROAD DECATUR, TN 37322	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOUTH	JLD BE	(X5) COMPLETION DATE
	Resident #9 was ad 23, 2007, with diagrous Disorder, Traumatic Urinary Incontinence Pulmonary Disease Medical record revie (MDS) dated July 9, scored 13 out of 15 the Brief Interview for assessment to dete score of 13 to 15 inc Continued review of resident required lintransfers and dressist throughout the facility supervision and set. Medical record revied dated July 10, 2012 unsafe smoking(nfacility smoking policy safely smoke at desareas with supervisitorsC Ensure (name) does smoking area with supervised smoking area with supervised smoking assistance with light supervised smoking	Imitted to the facility on May noses including Depressive Brain Injury, Convulsions, e, and Chronic Obstructive wo of the Minimum Data Set 2012, revealed the resident possible correct answers on or Mental Status (BIMS - an armine cognitive abilities with a dicating mild dementia). If the MDS revealed the nited assistance of one with ling, was capable of moving ty and eating at mealtime with support of the resident's Care Plan revealed, "Potential for ame) is non-compliant with the pat timesGoal: (name) will signated times, in designated on of staff or family Current Approaches:#4. In the proposition of the staff or family current Approaches#4. In the proposition of staff or family current Approaches#4. In the proposition of the	F 2	280			

STATEMENT OF DEFICIENCIES (X1) PROVAND PLAN OF CORRECTION (DEN'	VIDER/SUPPLIER/CLIA FIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, IN	ıc		33	EET ADDRESS, CITY, STATE, ZIP COD 2 RIVER ROAD ECATUR, TN 37322	E .	
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280 Continued From page 20 the patio outside the facility. Interview on September 26, with the Administrator, in the confirmed the facility had be the resident having possessi past weekend (September 2 Continued interview confirme Practical Nurse #4 (LPN) had (September 22, 2012) and le regarding resident #9 having of cigarettes. Continued interview Administrator told LPN #4 to the cigarettes stating he/she had been approved for indep Continued interview confirme not have been allowed to kee Interview with the Director of DON's office September 26, confirmed the resident's care revised to include the most reresident's non-compliance with policy for not surrendering sindefore leaving the supervised Resident #34 was admitted to February 1, 2010, and readming 2012, with diagnoses including Obstructive Pulmonary Diseas Congestive Heart Failure, Per Disease, Anxiety, and Depresident scored 13 out of a positive Interview for Mental States.	conference room, en made aware of on of cigarettes this 2 and 23, 2012), ed the Licensed d called on Saturday of the amessage personal possession review confirmed the let the resident keep thought the resident endent smoking, ed resident #9 should ep cigarettes. Nursing in the 2012, at 3:30 p.m., plan had not been ecent episode of the the smoking moking materials if area. O the facility on itted on May 1, ag Chronic se, Hypertension, ripheral Vascular ssive Disorder. quarterly Minimum 8, 2012, revealed the essible 15 on the	F2	280			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445278	B. WIN	IG_		10/0	1/2012
	ROVIDER OR SUPPLIER	INTER, INC		33	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 280	assessment of cogning to 15 indicating in Continued review retransfer self, ambult and off the unit with only. Continued reviews are used care 4 to 6 daily) that was necessident's goals for Medical record revied ated September 1 had been outside so When question how one had a lighter. It time the resident has been rights will be taken a (facility) Smoking Personal to 12, 201 search for cigs(cigal found in top drawer to 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said. Medical record revied ated September 15 (resident #34), to 15. In our rooms said.	ge 21 nitive abilities with a score of mild cognitive impairment.) evealed the resident could ate in room, and motivate on supervision and set-up help view revealed resident #34 days a week (but less than essary to achieve the health and well-being. ew of the Social Service note 5, 2011, revealed, "Resident moking with another resident view light cigarettes, neither this is not the first or second as had a verbal warning, advised next time smoking away for three days per olicy. Will continue to ew of the Social Service note 2, revealed, "Did room rettes) and lighters both was of(resident #34) room. Talk oldwe are not to have themwould not do it again" ew of the resident's care plan 3, 2012, revealed, "Problem ervised smoking with staff at #34) will safely smoke at a designated areas with or family members/visitors	F:	280			
	incidents x (times) S the resident's care r	by) no smoking injuries or 30 days." Continued review of blan revealed, "Current Assist(resident #34) as					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	TED	
		445278	B, WIN	IG _		10/01	/2012
	ROVIDER OR SUPPLIER EWOOD NURSING CE	INTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 132 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	needed to designate designated times a Ensure(resident designated smokin materials" Conting an evealed end of the "Current (no year given), stainformation) - Water in(resident's) root (resident) slips outs smoked." Medical record revious Assessment for Sn September 13, 201 with minimal super Facility storage of the smoking by staff! Per policy." Review of the facility 1. Resident's cigarette resident's name on be allowed to smoking by staff! Per policy." Review of the facility 1. Resident's cigarette resident's name on be allowed to smoking staff! Per policy in the smoke to be 9AM - the sallowed to possess residents will smok directly supervised to go outside of but smoke at any time. Smoking Policy revive at Brooke Wolfferentiate between on-responsible residents	nd supervise smoking. 10. #34) does not leave g area with smoking nued review of the resident's a handwritten notation at the Approaches" dated June 18 #18 ting, "FYI (for your the for hidden cigarettes, lighter m, staff have suspected #34's Quarterly moking Safety dated 2, revealed, "Smokes safely wision. Smoking apron. #19 be ableded with the med room. 2. #19 will be kept at the med in the med room. 2. #19 will be labeled with the med each pack. 3. Residents will me every two hours. Smoke many aproper services #19 A. No resident will be many according a cigarette lighter. 5. All me in the designated area med in the med room of the med continued review of the mealed the following disclaimer, mod Nursing Center elect to not	F:	280			

PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPLI	
		445278	B. WIN	IG	10/0	1/2012
	ROVIDER OR SUPPLIER	INTER, INC		STREET ADDRESS, CITY, STATE, ZIP 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	facility that this best review revealed the signed by resident # Observation on Sepa.m., revealed resid a motorized chair the room, rode through the building, and dis at the end of the 10 the 100 hall exit doo 7:46 a.m., revealed motorized chair, smobservation revealed back toward the contintercepted by the A of Nursing (DON). Interview with the Act 26, 2012, at 10:00 a confirmed the follow some residents smoothing same of the exact his facility aware as rect ago; Had many continuous facility aware as rect ago; Had many continuous the facility aware as rect ago; Had many continuous facility aware a	suits this facility." Continued Smoking Policy had been #34 (no date noted). Intember 26, 2012, at 7:45 Item #34 exited the building in trough a door in the activities the courtyard at the back of sappeared behind the corner in hall. Observation outside for on September 26, 2012, at the resident seated on the oking a cigarette. Continued in the resident proceeded artyard where the resident was administrator, and the Director in the conference room wing; The facility was aware of oking unsupervised; Was not story of the problem, citing ent as three months to a year eversations with (resident upervised smoking and and lighters in the resident's rator was unsure if there were smoke unsupervised, citing rring to smokers) had in the osmoke unsupervised. The facility was aware of obtaining the smokers of the problem, citing ent as three months to a year exercised smoking and and lighters in the resident's rator was unsure if there were smoke unsupervised, citing rring to smokers) had in the osmoke unsupervised. The facility is a facility in the ent as three months to a year exercised smoking and and lighters in the resident's rator was unsure if there were smoke unsupervised, citing rring to smokers) had in the osmoke unsupervised.	F 2	280		

Facility ID: TN6101

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		445278	B. WII	NG _		10/0	1/2012
	ROVIDER OR SUPPLIER		. <u></u>	3:	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	via telephone, with confirmed a package confiscated from re 2012. Continued in search on this date and on September again observed brir Interview with the DDON's office Septe confirmed resident's revised to include the	ge 24 mber 26, 2012, at 3:00 p.m., Licensed Practical Nurse #5 ge of cigarettes had been sident #34 on September 22, aterview confirmed a room yielded additional cigarettes, 23, 2012, the resident was aging cigarettes to the room. Director of Nursing in the mber 26, 2012, at 3:30 p.m., s care plan had not been the most recent episode of the pliance with the smoking	F.	280			
	September 14, 201 Pneumonia, Chroni Dementia with Beha Fibrillation, Hyperte Disorder. Review of the list of facility as smokers,	admitted to the facility on 2, with diagnoses including ic Airway Obstruction, avior, Gouty Arthritis, Atrial insion, and Depressive fresidents identified by the revealed resident #58 king activities during breaks.			· · · · · · · · · · · · · · · · · · ·		
	Medical record reviewated September 1st documentation the been addressed on Interview on September 1st Licensed Pract	ew of the resident's care plan 4, 2012, revealed no resident's smoking habits had the care plan. nber 26, 2012, at 1:57 p.m., tical Nurse (LPN) #3 at the firmed resident #58 smoked					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		445278	B. WIN	IG		10/0	1/2012
	ROVIDER OR SUPPLIER	ENTER, INC		333	EET ADDRESS, CITY, STATE, ZIP CODE 2 RIVER ROAD ECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	IULO BE	(XS) COMPLETION DATE
F 280	the DON's office or confirmed the resid been addressed or Resident #55 was	Director of Nursing (DON) in n Sept. 26, 2012, at 2:15 p.m., lent's smoking habits had not	F2	280			
	Dementia with Beh Disease, Hypertens Diabetes. Medical record revisent to the local hofor evaluation. Correcord revealed the facility with a diagnand was to receive Medical record reviAugust 29, 2012, readdress the resider infection (UTI) and days. Interview with the A and Minimum Data 2012, at 3:20 p.m., confirmed the care address the resider antibiotics for UTI. The Immediate Jec September 22, 201 and was removed acceptable Allegatic	aviors, Chronic Kidney sion, Atrial Fibrillation, and sew revealed the resident was spital on September 19, 2012 attinued review of the medical resident was returned to the osis of urinary tract infection antibiotics for ten days. ew of the care plan dated evealed the care plan did not at having an urinary tract receiving antibiotics for ten assistant Director of Nursing Set Coordinator on Sept 25, at the nurse's station, plan had not been updated to at the trace of the care plan did not not been updated to at the nurse's station, plan had not been updated to at the nurse's station, plan had not been updated to not's UTI and receiving the pardy was effective from 2, through October 1, 2012, and on of Compliance, which diacy of the Jeopardy, was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		445278	B. WI	√G		10/01	/2012
	ROVIDER OR SUPPLIER EWOOD NURSING CE	ENTER, INC		33	EET ADDRESS, CITY, STATE, ZIP CODE 2 RIVER ROAD ECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	IULO BE	(XS) COMPLETION DATE
F 280	received and corre on-site by the surve through review of for resident interviews team verified the an an an area verified the an an area verified the an an area verified the securacy of the	ctive actions were validated by team on October 1, 2012, acility documents, staff and and observations. The survey llegation of compliance by: ents #81, #80, and #58 had or smoking safety; and residents who smoke at the esmoking assessments was curvey team through smoking sessions. ents #34, #53, #81, #80, #58 ducated on the facility's olicy. The survey team verified interview with resident #58 on 12, at 4:00 p.m. The survey and on september view with #80 on September view with #80 on September	F	280			

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		445278	B. WING		10/0	1/2012
NAME OF PROVIDER OR S		<u> </u>		REET ADDRESS, CITY, STATE, ZIP CO 332 RIVER ROAD DECATUR, TN 37322	· · · · · · · · · · · · · · · · · · ·	
POECIN /EACH (DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	t SHOULD BE	(X5) COMPLETION DATE
smoke brecigarettes be issued document families of the revise. 5. Verify care plans needs for Interview (2012, at 1 Quality As Administra Director of Activity Di Medical R Certified I Supervised formulate smoking a safety. Comembers had revised inserviced revised S revealed (1 mailed let smoked, in Policy. Comedical E Immediate.)	ed, meta eak. Resi and/or lig a 30 day ation con the smo d smokin ing reside shad bee smoking with the I 2:50 p.m surance ator, Diret f Nursing rector, B tecords, I Dietary M or) had m a plan re and to de ontinued of the Q ed the fact the resi moking F Social Se ters to th informing ontinued or Jeopar	I containers following each dents who are found with ghters in their possession will discharge notice. Review of firmed the residents and king residents were notified of g policy. ents #53, #9, #34, and #58's en updated to reflect the safety	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION ONIG	(X3) DATE SURVEY COMPLETED
		445278	B. WING	·	10/01/2012
	ROVIDER OR SUPPLIER	NTER, INC	s	STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES *MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	TID BE COMPLETION
F 309	The facility is recorrection for all cite 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessor maintain the high mental, and psychological in the mental in the significant mental mental mental mental mental mental mental mental menta	Assessment and Assurance equired to submit a plan of ed deficiencies. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical,	F 28		nd in the ntal and cordance
	by: Based on medical and interview, the fa physician's orders t antidepressant med of forty-three reside The findings include Resident #38 was a 18, 2012, and read with diagnoses include Pneumonia, Demer Hypertension, and a Medical record revie Evaluation & Manag 2012, revealed a re Lexapro (antidepress	ed: admitted to the facility on April mitted on August 17, 2012, uding Bibasilar Aspiration ntia, Senile Delusions,		What corrective action(s) will accomplished for those reside to have been affected by the deficient practice? 1. The MD was notified DON on 9/27/12, of the recommendation to in resident #38's Lexapre daily that was dated A 2012. Order received written to increase Le 20mg daily. How will you identify other rehaving the potential to be affected.	ents found alleged by the he ncrease to 20mg August 22, and xapro to

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		445278	B. WING	<u> </u>	10/0	1/2012
	ROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
	the facility's Quality Committee. The facility is recorrection for all cite 483.25 PROVIDE CHIGHEST WELL Bit Each resident must provide the necessor maintain the high mental, and psycho	Assessment and Assurance equired to submit a plan of ed deficiencies. ARE/SERVICES FOR EING receive and the facility must ary care and services to attain test practicable physical,	F 309	the same alleged practice(s) at corrective action will be taken 1. All current residents or records were audited DON and ADON on 9/2 verify no other resider received recommenda from the psychiatric country that had been filed with orders being written. It residents were found been affected.	edical by the 7/12, to t's had tions onsultant hout the	
	by: Based on medical and interview, the far physician's orders to antidepressant med of forty-three reside The findings include Resident #38 was a 18, 2012, and readr with diagnoses include the pheumonia, Demen Hypertension, and A Medical record revise Evaluation & Manag 2012, revealed a recute the present the presen	o administer an increase in an ication for one resident (#38) ints reviewed. Id: Id: Id: Id: Id: Id: Id: I		What measures will be put place or what systematic of will you make to ensure the alleged deficient practice(s does/do not reoccur? 1. The Social Services Director forward all psych. recommendations to the and/or ADON, who will all psychiatric consultant recommendations as the received and notify MD recommendations and when orders as indicated	nanges at the ctor will ctor will review at ey are of write	

NAME OF PROVIDER OR SUPPLIER BROCKEWOOD NURSING CENTER, INC CAPID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY UST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY WITH TAG PROVIDE SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY (EACH CORRECTIVE ACTION (EACH CORRECTION (EACH CORRECTIVE ACTION (EACH CORRECT		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET					
RECOKEWOOD NURSING CENTER, INC CAPID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE (CROSS-REFERENCE OF OT HE APPROPRIATE DEFICIENCY) F 309 Continued From page 29 F 309 PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF OTHER APPROPRIATE DEFICIENCY PREFIX TAG F 309 Continued From page 29 F 309 PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF OTHER APPROPRIATE DEFICIENCY F 309 Medicine Evaluation & Management Note revealed the resident continued to receive Lexapro 10 mg daily. Observation on September 27, 2012, at 7:50 a m., revealed the resident lying on the bed, sleeping with a scoop mattress and a tabs alarm in place. Interview and review of the Behavioral Medicine Evaluation & Management Note, on September 27, 2012, at 8:45 a.m., with the Director of Nursing, in the conference room, revealed when the physician initialed the Behavioral Medicine Evaluation & Management Note the recommendation for the Lexapro to be increased to 20 mg was approved and ordered. Continued interview confirmed the physician's order was not followed. F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS PROVIDED FOR DEPENDENT RESIDENTS PROVIDED FOR DEPENDENT RESIDENTS PROVIDED FOR DEPENDENT RESIDENTS PROVIDED FOR daily living receives the precessary services to PREFIX TAG PROVIDED FOR daily living receives the providers and precedent providers plan of the plan of			445279			10/0	1/2012
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG RECULATORY OR LSC IDENTIFYING INFORMATION) TAG RECULATORY OR LARCH OR LAR				s			1/2012
F 309 Continued From page 29 Medicine Evaluation & Management Note revealed the physician had initialed the note. Medical record review of the August 23-31, 2012, and September 2012, Medication Record revealed the resident continued to receive Lexapro 10 mg daily. Observation on September 27, 2012, at 7:50 a.m., revealed the resident lying on the bed, sleeping with a scoop mattress and a tabs alarm in place. Interview and review of the Behavioral Medicine Evaluation & Management Note, on September 27, 2012, at 8:45 a.m., with the Director of Nursing, in the conference room, revealed when the physician initialed the Behavioral Medicine Evaluation & Management Note the recommendation for the Lexapro to be increased to 20 mg was approved and ordered. Continued interview confirmed the physician's order was not followed. F 312 SS=D DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receive the	BRUUKI	EWOOD NURSING CI	ENTER, INC		DECATUR, TN 37322		,
F 309 Continued From page 29 Medicine Evaluation & Management Note revealed the physician had initialed the note. Medical record review of the August 23-31, 2012, and September 2012, Medication Record revealed the resident continued to receive Lexapro 10 mg daily. Observation on September 27, 2012, at 7:50 a.m., revealed the resident lying on the bed, sleeping with a scoop mattress and a tabs alarm in place. Interview and review of the Behavioral Medicine Evaluation & Management Note, on September 27, 2012, at 8:45 a.m., with the Director of Nursing, in the conference room, revealed when the physician initialed the Behavioral Medicine Evaluation & Management Note the recommendation for the Lexapro to be increased to 20 mg was approved and ordered. Continued interview confirmed the physician's order was not followed. F 312 SS=D A resident who is unable to carry out activities of daily living receives the necessary services to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	(OULD BE	(X5) COMPLETION DATE
maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to reposition and	F 312	Medicine Evaluation revealed the physical record reviand September 20 revealed the reside Lexapro 10 mg dail. Observation on Sea.m., revealed the sleeping with a scolin place. Interview and reviee Evaluation & Mana 27, 2012, at 8:45 a Nursing, in the conthe physician initial Evaluation & Mana recommendation for to 20 mg was apprinterview confirmed followed. 483.25(a)(3) ADL COEPENDENT RESIDENT	iew of the August 23-31, 2012, 12, Medication Record ent continued to receive ly. ptember 27, 2012, at 7:50 resident lying on the bed, op mattress and a tabs alarm work of the Behavioral Medicine gement Note, on September .m., with the Director of ference room, revealed when led the Behavioral Medicine gement Note the or the Lexapro to be increased oved and ordered. Continued if the physician's order was not CARE PROVIDED FOR SIDENTS inable to carry out activities of a the necessary services to ition, grooming, and personal ordered record review, observation,	,	by the MD. How will the corrective action monitored to ensure the alleg deficient practice(s) will not rewhat quality assurance prograput into place? 1. DON and/or ADON wall psychiatric consult recommendations, Maresponse, and verify of written as indicated warecommendations are from Psych. Services Consultants. Report recommendations are response will be subtine QA committee for months, beginning in F-312 Resident's who are unable to activities of daily living received necessary services to maintain nutrition, grooming, and personal hygiene. What corrective action(s) will accomplished for those residentians.	ects be ged ecccur; am will be ant D orders are when e received mitted to or 3 or October. It carry out the fin good sonal and I be ents found	11/15/12

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
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	ROVIDER OR SUPPLIER		33	EET ADDRESS, CITY, STATE, ZIP CODE 2 RIVER ROAD ECATUR, TN 37322		
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F 312	one resident (#3) or reviewed. The findings included Resident #27 was 28, 2008, with diagon Depressive Disord Generalized Anxie Osteoarthritis, and Medical record revident had sever was always inconting was totally dependent transfers and bed Observation on Seam., until 11:15 and revealed the resident fidget alternately lying the Observation on Seam., revealed the with the head resticulation on Seam., revealed the with the head resticulation on Seam., revealed the with the head resticulation on Seam., revealed the the geri-chair to the geri-chai	ed: admitted to the facility on May moses including Dementia, er, Constipation, Anemia, ty, Hypertension, Esophageal Reflux. iew of the quarterly Minimum y 27, 2012, revealed the ely impaired cognitive skills, ment of bladder and bowel, and tent with two person assist for mobility. aptember 25, 2012, from 7:20 m., (3 hours and 55 minutes) ent seated in a geri-chair in the atable in front of the resident. ation during this time revealed ing with the tablecloth and e head on the table. Exprember 25, 2012, at 11:15 resident seated in a geri-chair ing on the table and the eyes expressed to the table and the eyes expressed. Continued observation ent had been incontinent of the right thigh and the right	F 312	1. Resident #27 has not experienced any negateffects resulting from in incontinence care be provided on 9/25/12. 2. Clothing for resident # been checked for approfit; Activity Director was notified of need for adclothing on 9/26/12 are obtained for resident # how will you identify other reshaving the potential to be affer the same alleged practice(s) are corrective action will be taken. 1. The CNA for resident # in-serviced on 10/16/1 DON, on incontinence frequency of checking incontinent episodes was assigned residents. 2. The CNA assigned for #3 has been in-serviced DON on 10/16/12, on residents in properly follothing and notification Charge Nurse, Social St.	the delay eing 3 has copriate as Iditional ad was #3. sidents cted by ad what ? 27 was n 2 by the care and for with all resident ad by the dressing itting on to	

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				WELL BATE CIL	D) (EV
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLET	ED
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	ROVIDER OR SUPPLIER	NTER, INC		3:	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULO BE	(X5) COMPLETION DATE
F 312	with Certified Nurs assigned to care for room, revealed the geri-chair at appropriate the residual repositioning or incontreview on Octobe the Director of Nur revealed residents checked for incontreview too long. Resident #3 was a February 27, 2012	mber 25, 2012, at 11:17 a.m., ing Assistant (CNA) #1, (CNA or the resident), in the activity resident was placed in the ximately 6:50 a.m., and dent had not been offered continence care since 6:50 a.m. er 1, 2012, at 9:35 a.m., with sing, in the business office, were to be repositioned and inence every two hours, and ours and fifty-five minutes was admitted to the facility on with diagnoses including	F	312	3. Staff will be in-service DON, on 10/23/12 re incontinence care and clothing. What measures will be put in what systemic changes will ye ensure the alleged deficient places/do not reoccur? 1. The Administrator, DO and Activity Director monitor for compliance incontinence care and	eds. ed by the garding d residents to place or ou make to practice(s) on, ADON, will be with the proper	
	Abuse, Borderline Palsy, Congestive Pain, Tic Douloure Reflux Disease. Medical record rev Data Set (MDS) a 2012, revealed, th memory problems cognitive skills for Continued review totally dependent dressing, was non incontinent of blace Review of the resi 12, 2012, revealed	Cognitive Disorder, Alcohol Personality Disorder, Bells Heart Failure, Chronic Back eux, and Gastroesophageal view of the quarterly Minimum essessment dated August 11, e resident had short/long term and severely impaired daily decision making. revealed the resident was on staff for transfers and eambulatory and always lider and bowel. dent's Care Plan dated August d, "Problem #5: Resident is for ADL's (activities of daily mosis of advanced dementia		, .	fitting clothing for res week x 3 months by observation rounds; b 10/15/12. How will the corrective actio monitored to ensure the alle deficient practice(s) will not what quality assurance progr put into place? 1. Results of monitorin will be reported to to Committee monthly months, beginning in	n(s) be ged reoccur; ram will be g activity he QA x 3	11/15/12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		445278	B. WING	·	10/01/2012
	ROVIDER OR SUPPLIER	NTER, INC		REET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	
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F 312	ADL needs met by a dry appropriate personaintenance of digramaintenance of digramaintenance of digramaintenance of digramaintenance of digramaintenance of digramaintenance of the continued or resident appeared the chin resting observation reveale large neck opening was hanging down a shoulder, exposing the course did not fit proshoulder should not opening in the neck revealed the resider	~	F 312		
F 323 SS=K	environment remain as is possible; and e	F ACCIDENT VISION/DEVICES sure that the resident as as free of accident hazards each resident receives on and assistance devices to	F 323	F-323- The facility ensures that the reenvironment remains as free accident hazards as is possible each resident receives adequasupervision and assistance deprevent accidents.	of e; and te

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
	445278	B. WING		10/01/201	2
NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CEI		s	TREET ADDRESS, CITY, STATE, ZIP COD 332 RIVER ROAD DECATUR, TN 37322		
PRESIVE (FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(XS) PLETION)ATE
by: Based on medical review, observation, failed to supervise s #34, #81, #80, #58, identified as smoker reviewed. The facility's failure #81, #80, #58, and #(situation in which a with one or more rechas caused, or is lik harm, impairment, osmoking. The Nursing Home Director of Nursing Immediate Jeopardy 4:00 p.m., in the cor F 323 cited at a sco substandard quality The findings include Resident #53 was a August 20, 2010, wi Dementia with Beha Depressive Disorde Medical record revieue Data Set dated Augresident scored 15 of Mental Status (8)	ecord review, facility policy and interview, the facility moking for six residents (#53, and #9) of nineteen residents of forty-three residents of forty-three residents of lambda for six noncompliance quirements of participation ely to cause serious injury, or death) from unsafe Administrator (NHA) and the (DON) were notified of the yon September 26, 2012, at inference room. pe and severity level of "K" is of care. ed: admitted to the facility on ith diagnoses including eviors, Diabetes Mellitus,	F 32	What corrective action(s) will accomplished for those resid to have been affected by the deficient practice? 1. Residents #3 and #55 immediately counsel (9/26/12) by DON and Administrator and exproduced a partial city (Resident #38) and attended (Resident 53). 2. The rooms and person Residents #38 and #1 thoroughly searched permission, 9/26/12 DON and ADON. 3. The rooms of all smooth obtaining permission thoroughly searched by the Social Service. 4. A memo & in service regarding discipline responsibilities regarding discipline responsibilities regarding that there at unsupervised smoking permission that there are a unsupervised smoking permission that there are unsupervised smoking permission.	ents found alleged were ed d ventually garette lighter ons of 53 were i, with their by the okers after n were I 9/26/12, s Director. e to staff & rding the olicy and ire no ers in the and in in 9/26/12,	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	
		445278	B. WING _		10/01/2012
BROOKE	ROVIDER OR SUPPLIER	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322 PROVIDER'S PLAN OF CORRECT	TION (X5)
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F 323	with ambulation. Medical record revi Assessment for Sm 2012, revealed " supervisionSmok tobacco products tobacco products Medical record revi August 10, 2012, re (related to) smoking requires supervision smoking policy" Medical record revi February 17, 2012, nurse was on lunch (certified nursing as out to smoke area favor?" This nurse permit you to smok smoke time."This into facility (and) re visible. This nurse. res. digging in stan the top (and) was b (cigarettes) that we informed that it was return to(room) bent over going the buttstold once ag toroomcont. to smoking policy"	y intact) and was independent	F 323	5. Resident smoking policy and in servicing of all st began 9/26/12 and corn on 9/29/12, by the DOI 6. Revised Resident smok policy was given to soo worker to be mailed to family members 9/26/2 will be included in admipackets as indicated. 7. All family members of were called by SSD and informed of the letter/they would be getting. 8. Smokers info book creating the DON, on 9/26/12 wincludes the list of names smokers in the facility sign out sheet for the distaking residents out break to sign and the ris checking the cigarett lighters back in to measure to sign that all an accounted for. 9. List of Smokers and smipolicy posted in break nursing station and in info book 9/26/12, by Administrator and DO	aff inpleted N. ing ial o all 12 and dission smokers I /policy 9/28/12. ated, by which nes of all and a CNA who to smoke nurse who tes, dication re noking room, at Smokers the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		TIPLE CONSTRUCTION	(X3) DATE	SURVEY LETED
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PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
went outback outsid what resident was d cigarette. Resident i Resident then came Resident asked to g refused then was tol Resident then broug Review of the facility "The following smodesignated to respect safety of our resident explained to resident on admission and as cigarettes and lighter supervised smoking necessary. They will accessible to staff or premises will be limit and scheduled areas accompanied by their visitorsThree episons smoking policy will resident yield provided butter on September 2012, at 7:55 a.m., will be cigarettes and inter 2012, at 7:55 a.m., will be cigarettes and inter 2012, at 7:55 a.m., will be cigarettes and inter 2012, at 7:55 a.m., will be cigarettes and inter 2012, at 7:55 a.m., will be cigarette.	2012, revealed "Resident e. When nurse went to see oing (resident #53) had a lit instructed to throw away cig. inside cussing at staff. ive nurse lighter. Resident Id administrator would be call. It lighter up to nurses" If policy (undated) revealed, oking policy and agreement is cit the rights and ensure the its. This agreement will be its and/or responsible parties is neededFacility will keep its for residents for whom has been deemed be kept in an area which is needed to the scheduled times in unless the resident is in responsible parties or ides of non compliance to the esult in suspension of or a specified time" Tember 26, 2012, at 7:50 and #53 obtained a cigarette is ash bin outside in the inued observation revealed in the cigarette. Continued no staff present in the review on September 26, ith the NHA and the DON, ig area, revealed the DON	F	323	10. Meeting held with all 9/26/12 to in service the revised smoking pathe Administrator and 11. All current smokers si copy of the smoking packnowledged they knowledged they	them on policy, by d DON. Igned a policy and new the violation ats #34 for a pon ent done wilding ing l by staff in ponal - 7 shift alicy will ge licy will on of Q sident	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE : COMPL	
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	Interview on Septement the hall, with Lice #2, confirmed LPN; residents who smoke the hall, with LPN #3 aware of all the residents who Septement the hall, with LPN #3 aware of all the resident with the DON, in the no investigations had determine how the non April 18, 2012. Interview on Septement with the NHA, in the the NHA was aware unsupervised smoking the nursing station, when the nursing station, which had a meeting became aware of the unsupervised on Fet documentation of the linterview on October 10:35 a.m., in the had atted August 10, 20 include the resident's supervised smoking ighter in their posses Resident #34 was additional supervised smoking ighter #34 was additional supervi	nber 26, 2012, at 11:40 a.m., nsed Practical Nurse (LPN) #2 was not aware of all the red. nber 26, 2012, at 1:50 p.m., in 3, confirmed LPN #3 was not dents who smoked. nber 27, 2012, at 1:10 p.m., conference room, confirmed deen completed to esident had obtained a lighter of resident #53's ng on February 17, 2012. 11, 2012, at 10:30 a.m., at with the NHA, confirmed the with resident #53's when eresident #53's when eresident #53's had not been updated to a noncompliance with or the resident with resident #53's ng on February 17, 2012, but had not the care plant 12, had not been updated to a noncompliance with or the resident having a	F3	323	room searches for 30 day until discharge, whiches comes first. How will you identify other residuating the potential to be affect the same alleged practice(s) and corrective action will be taken: 1. Any resident has the porto be affected by the same alleged deficient practice. 2. The rooms of all smoker thoroughly searched 9/2. 3. A memo & in service to regarding discipline & responsibilities regarding resident smoking policy the fact that there are not unsupervised smokers in facility was prepared and service of staff begun 9/2 by the Administrator, DO ADON. 4. Resident smoking policy mand in servicing of all staff began 9/26/12 and will be included with all new emporientation. 5. Revised Resident smoking policy was given to social worker to be mailed to all	dents ted by I what tential me	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	
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F 323 Continued From page 37 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Anxiety, and Depressive Disorder. Medical record review of the Minimum Data Set dated September 26, 2012, revealed the resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS - An assessment of cognitive abilities, 13-15 cognitively intact). Continued review revealed the resident could transfer self, ambulate in room, and motivate on and off the unit with supervision and set-up help only. Continued review revealed resident #34 refused care 4 to 6 days a week (but less than daily) that is necessary to achieve the resident's goals for health and well-being. Medical record review of the Social Service note dated September 15, 2011, revealed, "Resident hab been outside smoking with another resident. When question how they light cigarettes, neither one had a lighter. This is not the first or second time the resident has been advised next time smoking rights will be taken away for three days per Brookewood Smoking Policy. Will continue to monitor." Medical record review of the Social Service note dated June 12, 2012, revealed, "Did room search for cigic(igarettes) and lighters both was found in top drawer of(resident #34), toldwe are not to have them in our roomssaidwould not do it again" Medical record review of the resident's care plan dated September 13, 2012, revealed, "Problem	

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	AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA /OENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION		E SURVEY IPLETED
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		#13 Smoking: SupstaffGoal #1(resat designated times supervision of staff AEB (as evidenced incidents x (times) of the resident's care papproach(es)#9 needed to designate designated times and Ensure(resident # designated smoking materials" Continucare plan revealed a end of the "Current A (no year given), stati information) - Watch in(gender) room, s	ervised smoking with sident #34) will safely smoke, in designated areas with or family members/visitors by) no smoking injuries or 80 days." Continued review of plan revealed, "Current Assist(resident #34) as ed smoking area at ed supervise smoking. 10. 34) does not leave area with smoking ued review of the resident's handwritten notation at the Approaches" dated June 18	F3	23	13. Smoking perimeters is checked and monitor every shift for violatic smoking policy. Addit perimeter checks on initiated 10/1/12 14. Violation of smoking presult in 30 day discharge also result in the initiation of smoking palso result in the initiation and continued room searches for 30 discharge, whichever of first.	ed by staff ons in tional 11-7 shift colicy will arge tion of Q esident's d'daily days or	
	F F C b ti	Assessment for Smo September 13, 2012, with minimal supervis Facility storage of tob smoking by staff No ber policy." Review of the facility's 1. Resident's cigarett surse's station tocked Resident's cigarettes esident's name on ea e allowed to smoke of mes to be 9AM - 8PM llowed to possess a llowed to possess a	revealed, "Smokes safely sion. Smoking apron. sacco productsSupervised change-continue smoking s Smoking Policy, revealed, tes will be kept at the in the med room. 2. will be labeled with the ach pack. 3. Residents will every two hours. Smoke M. 4. No resident will be cigarette lighter. 5. All			What measures will be put into what systematic changes will y to ensure that the alleged defic practice(s) does/do not reoccur. 1. Smoking assessments we completed by the admit Charge Nurse on all new admission residents who smoke. Safe smoking interventions will be into on each new admission care plan for new admission.	ou make cient r: vill be tting v o cluded interim	
	re	nowed to possess a desidents will smoke in	cigarette lighter. 5. All n the designated area			care plan for new admis residents who smoke.	ssion	

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	directly supervised. to go outside of buil smoke at any time.' Smoking Policy reve "We at Brooke Wood differentiate betwee non-responsible restacility that this best review revealed the signed by resident # Observation on Septa.m., revealed reside a motorized chair the room, rode through the building, and distat the end of the 100 revealed the resident chair smoking a cigar revealed the resident courtyard and was appropriately and was approved the resident courtyard and was approved the resident smoking materials afficiently and a lighter was removed from the resident #34 declined the resident #34 declined the review with the Admitterview	6. Resident's will be allowed ding with family members to Continued review of the ealed the following disclaimer, of Nursing Center elect to not in responsible and idents. We feel that for the of the residents and our suits this facility." Continued Smoking Policy had been 34 (no date noted). Itember 26, 2012, at 7:45 and #34 exited the building in rough a door in the activities the courtyard at the back of appeared behind the corner hall. Continued observation to seated on the motorized rette. Continued observation to proceeded back toward the opposite proceeded back toward the opposite proceeded by the rector of Nursing (DON). In on September 26, 2012, and the facility's investigation had denied possessing the morning incident. Confirmed with the resident's left oved from the resident's left.	F	323	2. All smokers' rooms we searched every day (9/26/12) for two we social services, nursi restorative & other administrative staff thave gone 2 weeks we smoking materials be discovered. 3. Upon completion of week rounds to smok and person, with perwill be searched week social services, nursing administrative staff fromoth, then monthly necessary. 4. Any resident who vio policy and is found so unsupervised or with lighters in their posses be placed on q 15 min checks and daily room. How will the corrective action monitored to ensure the alleg deficient practice will not recupuality assurance program will into place? 1. All smokers' rooms with searched every day for	beginning eks by ing, antil they without any eing the daily-2 kers rooms mission, kly by ing & other or one as lates the noking tobacco, ssion will nute in checks. (s) be ed ir; what il be put		

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tt Raid Mire to the beautiful to the bea	some residents smo sure of the exact his facility aware as recordago; Had many con #34) regarding unsu keeping cigarettes a room; and Administrates who could believed some (refersmokers) had in the unsupervised. Resident #81 was ad September 12, 2012, Right Hip Fracture, Under Hip Fra	ring: The facility was aware of oking unsupervised; Was not story of the problem, citing ent as three months to a year versations with(resident pervised smoking and nd lighters in the resident's ator was unsure if there were smoke unsupervised, citing ring to past been allowed to smoke imitted to the facility on with diagnoses including rinary Tract Infection, dypertension. If you have a series on the Minimum Data Set 2012, revealed the resident sible correct answers on Mental Status assessment and for cognitive functioning indicates severe cognitive ed review revealed the nsive assistance with personal hygiene.	F 3		weeks (beginning Social Services, in Restorative nursi administrative st have gone 2 wee smoking material discovered. 2. Upon completion of week rounds to smand person, with person week rounds to smand person, with person the monthly as needs. 3. Administrative staff then monthly as needs. 3. Administrative Staff Administrator, Busing Manager, Activity Differences, and Nurse Supervisors, will monthly as needs. Supervisors, and Nurse Supervisors, will monthly as needs.	g 9/26/12) by sursing, ing and other aff until they ks without any is being for the daily 2 okers rooms ermission, will by social other for one month cessary. i, including the ness office irector, Human ing nitor each appliance with beginning g activities will Morning itor, DON, hab, ry, Activity ed by Risk		

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F f. a Made of the contract of	Interview with the A (ADON) in the Direct on September 26, 2 the Safe Smoking Electord was not complete an resident's ability to see a second Resident #80 was an August 23, 2012, with Urinary Tract Infection weakness, Abnormathypothyroidism. Medical record review Data Set dated Auguresident scored 14 or answers on the BIMS to 15 indicates mild of Continued review reversive assistance personal hygiene, and help only at mealtime Review of the list of reactifity as smokers, reactive smoker. Medical record review review of the list of reactifity as smokers, reactive smoker. Medical record review review assessment titled, Safeted August 13, 2011 was a two-sided assessment seed of the assompleted, leaving the esident's ability to smokers ability to smokers and the seident's ability to smokers	ssistant Director of Nursing ctor Of Nursing (DON) office (012, at 2:30 p.m., confirmed evaluation in the medical and did not identify the smoke safely. Idmitted to the facility on the diagnoses including con, Failure to Thrive, Muscle lity of Gait, and w of the admission Minimum ast 30, 2012, revealed the ut of 15 possible correct assessment (a score of 13 cognitive impairment). It is a seem of the resident required with transfers, dressing, d supervison with set-up	F3	123	Treatment Nurse, Dietary, Restorative) and QA comming in Octo	ttees x	11/15/12
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F 323	September 26, 2012 office, confirmed the	ge 42 2, at 2:30 p.m., in the DON's e resident had not been moking per the current facility	F3	323	1		
	September 14, 2012 Pneumonia, Chronic Dementia with Beha	dmitted to the facility on deciding the control of					
	Review of the list of a facility as smokers reactive smoker.	residents identified by the evealed resident #58 was an					
	Medical record review assessments revealed resident had been as	w of the resident's ed no documentation the sessed for safe smoking.					
	with Licensed Practic	per 26, 2012, at 1:57 p.m., al Nurse (LPN) #3 at the med resident #58 smoked loking breaks.			,		
	the DON's office on S confirmed resident #5 for safe smoking. Co Social Services was re nursing staff to the res	ector Of Nursing (DON) in lept. 26, 2012, at 2:15 p.m., is had not been assessed intinued interview confirmed esponsible for alerting sidents smoking preference, is ment should have been see who completes the lat.			•		
	Resident #9 was admi diagnoses including D	tted on May 23, 2007, with epressive Disorder,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION NG		(3) DATE SURVEY COMPLETED	
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	Traumatic Brain Injulation Incontinence, Gast and Chronic Obstrument Medical record reviet dated July 9, 2012, 13 out of 15 possible BIMS assessment was cognitive impairment the resident required transfers and dressillocomotion on the understand July 10, 2012, unsafe smoking (resident July 10, 2012, unsafe smoking (resident's redesignated times, in supervision of staff of members/visitors Censure (resident's redesignated smoking materials" Medical record reviet Assessment for Smo 2012, revealed, the reminimal supervision, facility storage of tob with lighting tobacco during smoking by stops of the server	ary, Convulsions, Urinary roesophageal Reflux Disease ctive Pulmonary Disease. Ew of the Minimum Data Set revealed the resident scored e correct answers on the with 13 to 15 being mild at. Continued review revealed dimited assistance for ng, and supervision for nit, and eating. Ew of the resident's Care Plan revealed, "Potential for sident's name) is acility smoking policy at times harne) will safely smoke at designated areas with prefamily current Approaches#4. Eame) does not leave area with smoking W of the Quarterly oking Safety dated July 10, esident smokes safely with uses a smoking apron, acco products, assistance products, and is supervised	F	323				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
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	Interview on Septem with the Administrat confirmed the facilit the resident having past weekend (September 22, 201 regarding resident # of cigarettes. Continued interview of cigarettes. Continued interview not have been allow Interview on Septem with staff person #1 knowledge of some breakfast to smoke the Continued interview named residents #9, group of non-compliant smoke by seasoned staff to #53, and #34 for unsucceptable Allegation removed the immediate cereview and correctived and correctived and correctived and correctived with elegation removed and correctived and correctived interview with Certific September 22, 2012 and was removed on acceptable Allegation removed the immediate cereview and correctived and correctived interview and correctived and correctived and correctives with the series of	nber 26, 2012, at 10:00 a.m., or, in the conference room, y had been made aware of possession of cigarettes this tember 22 and 23, 2012). confirmed the Licensed LPN) had called on Saturday 2) and left a message 9 having personal possession nued interview confirmed the PN #4 to let the resident keep g he/she thought the resident for independent smoking. confirmed resident #9 should ed to keep cigarettes. Aber 26, 2012, at 11:30 a.m., on the 200 hall, confirmed residents going out before without supervision. confirmed staff person #1 #53, and #34 as among the ant smokers. ad Nurse Aide (CNA) #5 on at 2:45 p.m. on the 100 ad no personal knowledge of ers, but had been instructed keep an eye on residents #9,	F	323			

Facility ID: TN6101

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED	
		445278	B, WIN	G	10/0	01/2012
	PROVIDER OR SUPPLIER	INTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	through review of faresident interviews, team verified the all 1. Verifying resider been reassessed for verifying the other refacility had accurate Accuracy of the smooth confirmed by the surposervation during servised smoking polithe information on in September 26, 2012 team verified the information on in September 26, 2012 team verified the information on in September 26, 2012 team verified the information on in September 26, 2012 team verified the information on in September 26, 2012 team verified the information on in September 26, 2012 team verified the information of the information of the information of the ensure a safe smoking residents. 3. Verifying the revipulation of the ensure a safe smoking residents. 4. Verification by the staff, and review of instaff received information of the info	ecility documents, staff and and observations. The survey egation of compliance by: Ints #81, #80, and #58 had a smoking safety; and esidents who smoke at the smoking assessments. Oking assessments was revey team through smoking sessions. Ints #34, #58, #81, #80, #58 ucated on the facility's licy. The survey team verified atterview with resident #58 on the stage of the survey team with resident #53 and interview on September ew with #80 on September	F 32	23		

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY LETED
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ľ	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	cigarettes and/or lig be issued a 30 day of documentation configation families of the smoke the revised smoking. 5. Verifying resider care plans had been needs for smoking. Interview with the Di 2012, at 12:50 p.m., Quality Assurance of Administrator, Direct Director of Nursing, Activity Director, Bus Medical Records, Marchael Certified Dietary Marchael Supervisor) had met formulate a plan relationsmoking and to deve safety. Continued intervised Smoking Polity revealed Social Serviced the resident revised Smoking Polity Continued interview. Continued interview informing the Policy. Continued interview inter	hters in their possession will discharge notice. Review of irmed the residents and iring residents were notified of policy. Ints #53, #9, #34, and #58's a updated to reflect the safety rector of Nursing October 1, revealed members of the ommittee (including the or of Nursing, Assistant Social Services Director, siness Office Manager, and Housekeeping on September 28, 2012, to ted to noncompliance with lop a plan to ensure resident terview revealed the lity Assurance committee lity Assurance committee cy's Smoking Policy, and and staff regarding the cy. Continued interview ces had contacted and amilies of the residents who em of the facility's Smoking erview revealed the facility's been made aware of the on September 28, 2012.	F	323			
tl	nonitoring corrective	ontinues at an "E" level for actions and evaluation by assessment and Assurance					·

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENT/FICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ge 47	 F3 	323			
F 333 SS=D	correction for all cite 483.25(m)(2) RESID SIGNIFICANT MED	ENTS FREE OF ERRORS ure that residents are free of	F3	33	F 333 The facility will ensure that resare free of significant medications.		
	by: Based on medical review, observation, failed to administer in one resident (#56) of observations. The findings included Resident #56 was reasent #56 was reasent Fibrillation, Diated Dementia, Psychosis Medical record review recapitulation orders or revealed the resident (insulin) 5 units at 7:0 Review of the facillity's Medications revealed be prepared in advance administered with one ime"	admitted to the facility on with diagnoses including petes, Hypertension, and Depression. of the physician's dated September 2012, was to receive Lantus 0 a.m. s policy Administering "9. Medications may not ce and must be (1) hour of their prescribed			What corrective action(s) will be accomplished for those resider to have been affected by the addeficient practice? 1. MD notified of resident receiving AM insulin late 9/24/12, by the Charge with no noted side effective new orders were received. How will you identify other residency are alleged practice(s) and corrective action will be taken? 1. Charge Nurse #2 complete medication error report reported medication error MD. Charge Nurse received training regarding medication error medication error medication error reported medication medication error reported medication error repor	t #56 te on Nurse cts. No red. dents ted by d what eted and or to red ration	
	Observation of a medi 24, 2012, at 9:20 a.m.	cation pass on September , revealed Licensed			administration on 10/12, the DON.	175 DA	

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		445278	B. WING	3	10/0	1/2012
	PROVIDER OR SUPPLIER	NTER, INC	5	STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323		ge 47 is required to submit a plan of	F 32	What measures will be put int what systematic changes will y to ensure that the alleged defi	ou make	
F 333 SS≃D		DENTS FREE OF	F 33	practice(s) does/do not reoccu 1. In-service for licensed		
	The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview the facility failed to administer insulin in a timely manner for one resident (#56) of ten resident medication observations.			staff on 10/23/12 by the for medication administ policy, timely delivery	e DON tration	
			i .	medications, medications, medications, medications, medications, will be done by DON at How will the corrective action (monitored to ensure the deficing practice will not reoccur; what assurance program will be put	d ADON. s) be ent quality	
	September 20, 2012 Atrial Fibrillation, Dia Dementia, Psychosis Medical record revie recapitulation orders revealed the residen (insulin) 5 units at 7:0 Review of the facillity Medications revealed be prepared in advar administered with on time"	eadmitted to the facility on a with diagnoses including abetes, Hypertension, so, and Depression. We of the physician's dated September 2012, to was to receive Lantus 200 a.m. It's policy Administering 1 "9. Medications may not once and must be e (1) hour of their prescribed		place? 1. DON, ADON, and/or Control Pharmacist will conduct medication pass observations and/or discipance action as indicated for compliance with medical administration proced Results of medication observations and medications are possible processes and medications are processes as a possible processes are processed as a possible processes are processes	vations nurses to e. Staff plinary non- cation ures. cass cation ported to	
	Observation of a med 24, 2012, at 9:20 a.m	dication pass on September ., revealed Licensed		the QA Committee mo months, beginning in C		_

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION NG	(X3) DATE COMPI	
		445278	B. WI	NG_		10/	01/2012
	PROVIDER OR SUPPLIER	ENTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	1X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	Practical Nurse (LP insulin 5 units to the Interview with LPN: 10:37 a.m., at the n Lantus (insulin) was prescribed time (2 h Interview with the Asseptember 27, 2012 Director of Nursing's was given past the	N) #2 administered Lantus		3333			
SS=D	SPREAD, LINENS The facility must estrated for Control Prosafe, sanitary and control provent the dof disease and infection Control The facility must esta Program under which (1) Investigates, continuing the facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection the Infection of the I	Program ablish an Infection Control h it - trols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection	F4	41	The facility has established and maintains an infection Control P designed to provide a safe, sanit comfortable environment and to prevent the development and transmission of disease and infection what corrective action(s) will be accomplished for those resident to have been affected by the alled deficient practice? 1. CNA #1 has received trait the DON on 10/16/12, regarding infection continand washing policy.	ary and to help ction. s found eged ining by	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE 8 COMPL	
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	PROVIDER OR SUPPLIER	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	prevent the spread isolate the resident. (2) The facility must communicable diserom direct contact will trace (3) The facility must hands after each direct washing is ind professional practical (c) Linens Personnel must hand	prohibit employees with a case or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted	F 4	41	How will you identify other resinating the potential to be affect the same alleged practice(s) and corrective action will be taken? 1. CNA's and licensed number in-serviced on hand policy on 10/23/12 by the what systemic changes you will ensure that the alleged deficient practice(s) does/do not reoccur	ted by d what ses will washing the DON. place or make to	
	by: Based on observation interview, the facility the hands after provious resident (#27) or reviewed. The findings included Observation on Septia.m., revealed resident the geri-chair to the trevealed the resident bladder and bowel, a Assistant (CNA) #1 pather resident. Continuater providing incontremoved the gloves are	ember 25, 2012, at 11:20 ent #27 was transferred from bed. Continued observation thad been incontinent of nd Certified Nursing rovided incontinence care to sed observation revealed			1. DON, ADON, Charge Nu will monitor for complia with hand washing follow incontinence care by observation of CNA's proincontinence care to our residents 3 times per we months, beginning 10/26. How will the corrective action(s monitored to ensure the alleged deficient practice will not reocci quality assurance program will linto place? 1. Results of the monitoring compliance will be track.	wing oviding eek for 3 5/12. be d ur; what be put	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	OULTIPLE CONSTRUCTION LDING	(X3) DATE COMPI	
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	PROVIDER OR SUPPLIER EWOOD NURSING CE	ENTER, INC		STREET ADDRESS, CITY, STATE, ZIP 332 RIVER ROAD DECATUR, TN 37322	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	from the clean lineral Review of the facility revealed "It is the powashing be regarded important means of infectionsAppropring performed under the offering incontinence blood, urine, feces, gloves did not replace the continence of the contine	y's policy Hand Washing policy of this facility that hand d as the single most preventing the spread of latehand washing must be a following conditionsafter a careafter contact with oral secretionsthe use of the hand washing" The property of the contact washing"	F4	the ADON and re QA committee n months, beginni November.	nonthly for 3	11/15/12
SS=K	the gloves, prior to of 483.75 EFFECTIVE ADMINISTRATION/ A facility must be ad- enables it to use its refficiently to attain or	RESIDENT WELL-BEING ministered in a manner that resources effectively and maintain the highest mental, and psychosocial	F 49	The facility is administere that enables it to use its rule effectively and effic iently maintain the highest practiphysical, mental and psychological peing of each resident.	esources to attain or ticable	
	by: Based on medical refacility policy review, failed to be administe an effective system wareplan and supervi#80, #58, and #9) for failure to ensure safe ikely to cause serious	r is not met as evidenced cord review, observation, and interview, the facility ared in a manner to ensure vas in place to assess, se residents (#34, #53, #81, safe smoking. The facility's smoking practices was injury, harm, impairment or 4, #53, #81, #80, #58, and		What corrective action(s) accomplished for those reto have been affected by the deficient practice? 1. Smoking Assessment plans for resident? #81, #80, #58, and reviewed by the M	sidents found he alleged ents and care s #34, #53, #9 were	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/X2) A	ALIL T	TIPLE CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A BU			COMPLI	
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NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
BROOK	EWOOD NURSING CE	INTER, INC		332 RIVER ROAD DECATUR, TN 37322			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490		ge 51 or all residents who smoke.	F4	190	Coordinator and revised indicated on 9/27/12.	d as	
	with the Administrate confirmed the facilit the resident having past weekend (Sept Continued interview Practical Nurse #4 ((September 22, 201 regarding resident # of cigarettes. Continued Lithe cigarettes stating	nber 26, 2012, at 10:00 a.m., for, in the conference room, by had been made aware of possession of cigarettes this tember 22 and 23, 2012). It confirmed the Licensed (LPN) had called on Saturday (2) and left a message (4) having personal possession in the left the resident keep of he/she thought the resident in the left in in the l	· //		2. The Regional Vice Presiover Operations had informulating the POC and on site to review the implementation of the November 2012. How will you identify other residuating the potential to be affect the same alleged practice(s) and corrective action will be taken?	put into id will be POC by idents " ited by d what	
	Continued interview not have been allow Refer to F272 for fai assessments. Refer to F280 for fai	for independent smoking. confirmed resident #9 should ed to keep cigarettes. lure to complete smoking lure to update care plans to			 Smoking assessments and plans were reviewed, by the Coordinator, DON and AD- revised as indicated for all residents that smoke at the facility, by 9/29/12. New 	he MDS ON, and le	
	Refer to F323 for fai the facility's policy to The Nursing Home A Nursing were notified	for residents' safe smoking. lure to supervise and follow ensure safe smoking. Administrator and Director of d of the Immediate Jeopardy 212, at 4:00 p.m., in the			admission care plans will be reviewed and revised as in What measures will be put into or what systemic changes you what to ensure that the alleged	ndicated. place vill	
	conference room. The Immediate Jeop September 22, 2012 and was removed on	ardy was effective from through October 1, 2012, October 1, 2012. An of Compliance, which			deficient practice(s) does/do no recur? 1. The QA Committee met 9/26/12 to review the fa smoking policy and practice.	on cility	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι' '	IULTIPLE COM	ISTRUCTION	(X3) DATE	SURVEY LETED
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	removed the immer received and correct on-site by the surver through review of faresident interviews, team verified the all 1. Verifying resident been reassessed for verifying the other refacility had accurate Accuracy of the smc confirmed by the survey observation during some servation during some servation during some servation on in September 26, 2012 team verified the information on through observation	diacy of the Jeopardy, was ctive actions were validated by team on October 1, 2012, actility documents, staff and and observations. The survey egation of compliance by: Ints #81, #80, and #58 had a smoking safety; and esidents who smoke at the smoking assessments. Soking assessments was revey team through smoking sessions. Ints #34, #53, #81, #80, #58 ucated on the facility's icy. The survey team verified atterview with resident #58 on the stage of the survey termation with resident #53 and interview on September ew with #80 on September	F 2	\$90	and developed an action ensure the safety of all resident's. The Smoking Policy was and reviewed with all re at the facility who smok Administrator and DON 9/26/12. All of these resacknowledged understathe revised smoking policy the revised smoking policy the safety of all residents. Notification was made to all family membresidents who smoke, by and phone calls by the S Services Director on 9/2	revised sidents e by the on idents nding of icy and he o	
1 2	policy with acknowle and agreement to the ensure a safe smoking esidents. 1. Verification by the	sion of the facility's smoking dgement of understanding e policy by the residents to ng environment for all e survey team on October 1, erviews with multidisciplinary		3.	All Staff members at the were in-serviced on the re Resident Smoking Policy a Facility Protocol for Resid Smoking and ensuring the cigarettes and lighters we	evised and lent at all	
s s n a	staff, and review of in staff received informate evised smoking police to ensure that all	iservice logs confirmed the ation regarding the facility's by including staff members cigarettes and lighters are up in the medication room,			locked up in the medication room and all cigarette but were collected following a smoke break. Staff in-services.	on tts each	

STREET ADDRESS, CITY, STATE, 2IP CODE PROVIDERS PLAN OF CORRECTION CORRECTION		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE S COMPLI	
BROOKEWOOD NURSING CENTER, INC 332 RIVER ROAD DECATUR, TN 37322			445278	B. WII	NG _		10/0	1/2012
F 490 Continued From page 53 and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking pesicients were notified of the revised smoking policy. 5. Verifying residents #53, #9, #34, and #58's care-plans had been updated to reflect the safety needs for smoking. Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Confinued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy. Continued interview revealed the mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility is medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.			NTER, INC		3	32 RIVER ROAD		
and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy. 5. Verifying residents #53, #9, #34, and #55's care plans had been updated to reflect the safety needs for smoking. Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director, Discort, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
Non compliance continues at an "E" level for October.		and that cigarette be in the locked, metal smoke break. Reside cigarettes and/or lighted be issued a 30 day documentation configamilies of the smoking of the smoking. 5. Verifying reside care-plans had been needs for smoking. Interview with the D 2012, at 12:50 p.m., Quality Assurance of Administrator, Director of Nursing, Activity Director, Bust Medical Records, M Certified Dietary Ma Supervisor) had met formulate a plan relasmoking and to deves safety. Continued in members of the Quahad revised the facil inserviced the reside revised Smoking Porevealed Social Servinalled letters to the smoked, informing the Policy. Continued in Medical Director had Immediate Jeopardy	utts are collected and placed containers following each dents who are found with hters in their possession will discharge notice. Review of firmed the residents and ting residents were notified of a policy. Ints #53, #9, #34, and #58's a updated to reflect the safety director of Nursing October 1, revealed members of the formittee (including the stor of Nursing, Assistant Social Services Director, siness Office Manager, aintenance Supervisor, aintenance Supervisor, anger, and Housekeeping on September 28, 2012, to sted to noncompliance with elop a plan to ensure resident atterview revealed the lity's Smoking Policy, and ents and staff regarding the licy. Continued interview rices had contacted and families of the residents who mem of the facility's Smoking terview revealed the facility's been made aware of the on September 28, 2012.	F		was completed on 10/01/11 the Administrator, DON and ADON. 4. A monitoring system to ensist compliance with the Smoking Policy was put in place on 9/26/12, to ensure compliance with safe smoking practices Facility staff and Licensed Nurses will ensure that all cigarettes and lighters are returned to be locked up following each smoke breat Facility staff will ensure that cigarette butts are collecte and placed in locked, metatontainers. The Social Service Director or designed will perform room searches for contraband as indicated by facility policy. How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur what quality assurance program will put into place? 1. Results of the monitoring system audits will be review by the QA Committee mon x 3 months, beginning in	d sure ing ance s. k. at all d ices the ithe ithe wed	11/15/12

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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ļ	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC] 3	REET ADDRESS, CITY, STATE, ZIP CODE 132 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		. PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	monitoring corrective the facility's Quality Committee.	e actions and evaluation by Assessment and Assurance quired to submit a plan of	F4	1 90			
	483.75(e)(8) NURSI REVIEW-12 HR/YR	E AIDE PERFORM	F4	97	F 497	•	-
	of every nurse aide a months, and must p education based on reviews. The in-sen- sufficient to ensure to nurse aides, but must per year; address and determined in nurse and may address the as determined by the aides providing servi-	he continuing competence of st be no less than 12 hours eas of weakness as aides' performance reviews a special needs of residents a facility staff; and for nurse ces to individuals with s, also address the care of			The facility completes annual performance reviews for all nur assistants and provides in-servi education based on the outcomperformance reviews and need resident's. What corrective action(s) will be accomplished for those resident to have been affected by the all deficient practice? 1. Review of CNA hire dates	ce ne of s of the e ts found eged s, by the	
i i i i i i i i i i i i i i i i i i i	by: Based on review of I Based on review of I Band interview, the fac- nurse aides had 12 h per year for six of twe reviewed. The findings included Review of the nurse a locumentation reveal	r is not met as evidenced nurse aide in-service hours illity failed to ensure the ours of inservice education enty-three nurse aides			ADON, for annual performance reviews and in-service expressed 5 of the 6 CNA's insufficient in-service how incorrect hire dates listed in-service records; only 1 CNA's had actually failed complete the required arms service training hours. The had 10.25 in-service training hours with 1.45 hours necessions.	lucation with urs had fon the of the to unual in- is CNA	

PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		IPLE CONSTRUCTION	(X3) DATE COMPI	
		445278	B. Wil	NG_		10/	01/2012
•	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 132 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	monitoring corrective the facility's Quality Committee.	e actions and evaluation by Assessment and Assurance quired to submit a plan of d deficiencies.	 F4	97	10/1/2012. This CNA has completed the remainder in-service education hours 10/11/12. How will you identify other emp	s on	
SS=E	REVIEW-12 HRYR The facility must cor of every nurse aide a months, and must preducation based on reviews. The in-serv sufficient to ensure t nurse aides, but must per year; address and determined in nurse and may address the as determined by the aides providing servi	INSERVICE Inplete a performance review at least once every 12 Trovide regular in-service the outcome of these vice training must be the continuing competence of st be no less than 12 hours eas of weakness as aides' performance reviews a special needs of residents a facility staff, and for nurse ces to individuals with s, also address the care of			having the potential to be affect the same alleged practice(s) and corrective action will be taken? 1. The ADON reviewed all service records, on 9/25 and corrected hire date review date for previou incorrect in-service training records for the CNA's. A all CNA's was compiled current hours that were by the next performance and the date by which the	CNA in- 0/12, /annual s ning log of listing needed e review	
-	by: Based on review of rand interview, the factorise aides had 12 has per year for six of two reviewed. The findings included Review of the nurse adocumentation reveal.				service hours must be completed. The CNA's w instructed during the inon 10/8/12 by the DON, regarding the in-service education requirements. service hours log was pothe employee break-room. What measures will be put into put what systemic changes will you measures.	The instead in m.	

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STATEM	ENT OF DEFICIENCIES	CAN DECIDENCES				OMB NO	D. 0938-0391
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION NG	(X3) DATE	
		445278	B. WI	NG_		l	
[F PROVIDER OR SUPPLIER KEWOOD NURSING CE SUMMARY STA	NTER, INC TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322 PROVIDER'S PLAN OF CORRECT	TION	01/2012
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JI D RE	(X5) COMPLETION DATE
F 49	monitoring corrective the facility's Quality and Committee.	ge 54 e actions and evaluation by Assessment and Assurance guired to submit a plan of	•	,	ensure that the alleged deficient practice(s) does/do not reoccur? 1. An Annual In-Service cal was posted in the emplo	? endar	
F 497 SS=E	The facility must come of every nurse aide a months, and must preducation based on treviews. The in-servisufficient to ensure the nurse aides, but must per year; address are	d deficiencies. AIDE PERFORM INSERVICE Inplete a performance review t least once every 12 ovide regular in-service the outcome of these the ce training must be the continuing competence of the performance of the performa		97	break-room on 10/01/12 ADON. ADON will check beginning of each month Annual Performance Evaluations due in the mi and review with CNA In-S records to ensure require service hours have been completed prior to Annua	2 by the cat the for onth ervice ed in-	
	and may address the as determined by the aides providing service cognitive impairments, the cognitively impaire. This REQUIREMENT	also address the care of			Performance review date. service training hours will calculated annually by dat hire. How will the corrective action(s) be monitored to ensure the alleged	be e of	
	by: Based on review of nu and interview, the facili	rse aide in-service hours ty failed to ensure the Irs of inservice education			deficient practice will not reoccur; quality assurance program will be printo place? 1. ADON will monitor for completion of required inservice education hours, ear	but	
d	Review of the nurse aid locumentation revealed urse aides employed b	Six of the twenty-three			month, beginning in Octobe prior to completion of the annual performance review		

	TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445278	B. WING			10/01/2012	
	PROVIDER OR SUPPLIER	NTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 132 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 497	received the require Interview with the A October 1, 2012, at room, confirmed the	ge 55 ed 12 hours per year. ssistant Director of Nursing on 3:00 p.m., in the conference e six nurse aides had not rs of the required inservice	F	497	will report the results to Committee for 3 month beginning in October. (0) 26 12 12 14 15 14 15 14 15 14 15 15	15,	11/30/12 11/15/17
SS=D	services to meet the facility is responsible of the services. This REQUIREMEN by: Based on medical rereview, and interview lab work timely for or forty-three residents. The findings included Resident #69 was ad 8, 2010, and readmit with diagnoses including Disease, Convulsions Gastroesophageal Review of the Physicial Review of the Physicial Parameters.	evide or obtain laboratory eneeds of its residents. The effor the quality and timeliness. T is not met as evidenced ecord review, facility policy with facility failed to obtain the resident (#69) of reviewed. In itted to facility on October ted on February 13, 2012, ding End Stage Renals, Hypertension, effux Disease, Peripheral ementia without Behaviors, Diabetes, and	F.5	602	The facility provides and obtains laboratory services to meet the rof its residents. What corrective action(s) will be accomplished for those residents to have been affected by the alledeficient practice? 1. The medical record for reference was reviewed to ensure obtained as indicated by routine lab and MD orded the ADON on 9/27/12. How will you identify other residents was alleged practice(s) and corrective action will be taken? 1. The medical records for a current residents were a to ensure orders were in for all routine lab orders	reeds found ged esident cure all ed to be rs, by lents ed by what all udited place	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445278	B. WING _		10/01/2012	
	ROVIDER OR SUPPLIER WOOD NURSING CE	NTER, INC	3	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 502	Sodium (thyroid me tablet 1 by mouth etablet 1 by m	dication) 25 mcg (microgram)	F 502	ADON and completed of 10/23/12. What measures will be put into what systematic changes will yo to ensure that the alleged deficipractice(s) does/do not reoccur 1. The ADON will maintain tracking log for all routin orders to ensure labs an obtained as ordered. The ADON will review orders morning and add new of the lab log as orders are received from the MD. How will the corrective action(s monitored to ensure the allege deficient practice will not reoccupality assurance program will into place? 1. The ADON will monitor orders for achievement and will report on the completion of routine is orders to the QA Commmonthly x 3 months, be in October.	place or ou make ient ? a ne lab e ne s each rders to e d cur; what be put lab weekly	
F 514 SS≃D	483.75(I)(1) RES RECORDS-COMPL LE	ETE/ACCURATE/ACCESSIB	F 514	F 514 The facility maintains clinical re	1	
	The facility must ma resident in accordar	intain clinical records on each nce with accepted professional		each resident in accordance wit accepted professional standard		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A		TIPLE CONSTRUCTION	(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED	
}		445278	B. WI	NG_		10/0	1/2012	
	PROVIDER OR SUPPLIER EWOOD NURSING CE	ENTER, INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	KOULD BE	(X5) COMPLETION DATE	
	standards and practaccurately document accurately document systematically orga. The clinical record information to ident resident's assessmiservices provided; to preadmission scree and progress notes. This REQUIREMENT by: Based on medical in the facility failed to record for two residents. The findings included Medical record reviet April 18, 2012, reveated in the facility failed to receive Boost (nutrity for the findings included Medical record reviet for the findings included Medical record reviet for the findings included for the formation of the factory of the findings in the factor of the findings in the factor of the findings included for the factor of the findings in the factor of the factor of the factor of the findings in the factor of the findings in the factor of the factor of the factor of the factor of the findings in the factor of the factor o	tices that are complete; need; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ning conducted by the State; IT is not met as evidenced record review and interview, maintain a complete medical ents (#38, and #17) of a reviewed. It is not met as evidenced record review and interview, maintain a complete medical ents (#38, and #17) of a reviewed. It is not met as evidenced record review and interview, maintain a complete medical ents (#38 was to include the reviewed. It is not met as evidenced record review and interview, maintain a complete medical ents (#38 was to include the reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review and #17) of a reviewed. It is not met as evidenced record review.		514	documented, readily accessib systematically organized. What corrective action(s) will accomplished for those reside to have been affected by the adeficient practice? 1. Resident #38 receives twice daily with her means and not as a supplement. 2. Resident #17 failed to Geodon documented for the evening dose. Staff were in-serviced 10/23/12 by the DON accurate documentatic supplement intake. How will you identify other rehaving the potential to be affithe same alleged practice(s) accorrective action will be take 1. The CDM has reviewed nutritional supplement residents and provide	e, and be nts found alleged Boost eals. as rest of a separate have as given Nursing on on of esidents ected by and what an? ed nts for all ed the DON		
	supplement). Interview of Septem with the Certified Die resident had receive admission to the factoriew on Septem with the Director of N	ber 27, 2012, at 9:50 a.m., etary Manager revealed the d Boost twice daily since ility. ber 27, 2012, at 12:30 p.m., lursing (DON), in the DON's re was no documentation the			having the potential to be aff the same alleged practice(s) a corrective action will be take 1. The CDM has reviewe nutritional suppleme	ected by and what n? ed nts for all ed the DON		

	CTATEL		THE BIOMB OCITATORS	,			OMR M	J. 0938 - 03	9
		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
			445278	B. WII	NG		10/	01/2012	
ı	NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS CITY STATE TIP CORE	1 107	U 1720 12	_
I	BROOK	EWOOD NURSING CE	NTER, INC			TREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD			
ŀ		SUBMIT THE PARTY		, . <u>.</u>		DECATUR, TN 37322			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETIO DATE	N
	F 514	Continued From pag	ne 57	[F5	: 1 /	residents who have or	ders to		
			ices that are complete;	[[714	receive nutritional			
		accurately documen	ted; readily accessible; and			supplements. All resid	lents who		
		systematically organ	ized.			receive nutritional sup	plements		
		The clinical record m	nust contain sufficient			will have these docum	ented	ĺ	
		information to identif	v the resident: a record of the			separately beginning in			1
	ļ	resident's assessme services provided; th	nts; the plan of care and			month of November of			
		preadmission screen	ing conducted by the State;			CNA ADL tracking form			
	-	and progress notes.	mig somestica by the charte,			2. Nutritional supplement	s will be		Ì
]		•			documented separately	from -		
	ļ	This REQUIREMENT	is not met as evidenced			meal consumption to		}	ı
	ĺ	by:				adequately monitor inta		ļ	-
		Based on medical re	cord review and interview,			supplements. All staff to			-
		record for two resider	aintain a complete medical			serviced on this procedu	re on		1
		forty-three residents i	eviewed.		ı	10/23/12 by the DON.		ļ	1
	}	The findings included			ļ	Nursing staff will receive			١
		The mongs moduled	'		ŀ	service training on 10/23		:	Í
	ļ I	Medical record review	of a Diet Requisition dated		- 1	the DON, on complete ar			1
	1:	April 18, 2012, reveal	ed resident #38 was to			accurate documentation			1
]'	receive boost (nutilitio	nal supplement) twice daily.		- [CNA- ADL Tracking Form.			1
	Ţ	Medical record review	revealed no documentation		1	What measures will be put into pl			1
		resident #38 received	Boost (nutritional			what systematic changes will you			1
		supplement).				to ensure that the alleged deficier	it		l
	11	nterview of Septembe	er 27, 2012, at 9:50 a.m.,			practice(s) does/do not reoccur?	ĺ		l
	įv	vith the Certified Dieta	ary Manager revealed the			DON or ADON will monitor	1		l
	i i i	esident had received Idmission to the facilit	Boost twice daily since			accurate documentation o	ŀ		
						nutritional supplements ar			
	ļ ir	nterview on Septembe	er 27, 2012, at 12:30 p.m.,			medication administration			
	W	ith the Director of Nu	rsing (DON), in the DON's was no documentation the			10 residents weekly x 1 mg	,		
	re	mice, commined there esident had received t	he Boost			then bi-weekly x 2 months	1	• •	
	1				1	beginning in November.	1.		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		445278	B. WIN	G	10/	01/2012	
i	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		STREET ADDRESS, CITY, STATE, ZIP (332 RIVER ROAD DECATUR, TN 37322	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520 SS=K	physician's orders, if resident was to receive medication) 60 mg (Medical record reviewed Medication Administ documentation their Geodon for August Interview on Septem with Licensed Practinursing station, revefacility full time (five had administered the evenings in August 2 confirmed there was Geodon 60 mg was in August 2012. 483.75(o)(1) QAA COMMITTEE-MEME QUARTERLY/PLANS	ew of the August 2012, for resident #17, revealed the eive Geodon (antipsychotic (milligrams) every evening. Ew of the August 2012, tration Record revealed no resident had received the 1-30, 2012. The 25, 2012, at 3:22 p.m., cal Nurse #1 (LPN), at the caled LPN #1 worked at the of seven days weekly) and a Geodon 60 mg in the 2012. Continued interview no documentation the administered in the evenings BERS/MEET Sein a quality assessment and a consisting of the director of	F 52	monitored to ensure the opractice will no recur; what assurance program will be place? 1. Results of monitor reported to the Quantity x 3 month in November, by the and/or ADON.	teficient of quality of put into ring will be A Committee of beginning the DON	11/15/12	
1	facility; and at least 3 facility's staff.	ervices; a physician designated by the hd at least 3 other members of the taff.		assessment and assurance necessary; and develop at appropriate plans of actio identified quality deficien	nd implements n to correct		
i	ssues with respect to and assurance activit develops and implem	which quality assessment ies are necessary; and ents appropriate plans of lified quality deficiencies.		What corrective action(s) accomplished for those re to have been affected by the deficient practice?	sidents found		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445278	B. WIN	1G _		10/0	1/2012
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC		3:	REET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8E	(X5) COMPLETION DATE
F 520	disclosure of the recepted insofar as succompliance of such requirements of this Good faith attempts and correct quality of a basis for sanction. This REQUIREMENT by: Based on facility intensure the Quality of a plan to address saresidents (#53, #34, nineteen residents in the facility's failure by reviewing data to improvement plans for resident who sme #34, #81, #80, #58, Jeopardy (situation in noncompliance with participation has causerious harm, injury, The Nursing Home of Director of Nursing (Immediate Jeopardy 4:00 p.m., in the control of the findings included.)	retary may not require cords of such committee uch disclosure is related to the committee with the section. It by the committee to identify deficiencies will not be used as s. IT is not met as evidenced terviews the facility failed to assurance Committee improvement and implemented afety with smoking for six #81, #80, #58, and #9) of dentified as smokers. It address residents' safety assist in formulating (for individual residents and oked) placed residents (#53, and #9) in Immediate in which a provider's one or more requirements of used, or is likely to cause impairment or death). Administrator (NHA) and the DON) were notified of the on September 26, 2012, at afference room.		520	 The QA Committee met 9/26/12 to review the fapolicy and practices for residents #53, #34, #81, and #9, and all other residents who smoke at the facilit. How will you identify other residents having the potential to be affect the same alleged practice(s) and corrective action will be taken? The facility implemented revised smoking policy and additional measures to essafe smoking practices for up all cigarettes and light the medication room, concigarette butts following resident smoke breaks. What measures will be put into put what systemic changes you will nemate that the alleged deficient practice(s) does/do not reoccur. CNAs, Charge Nurses we monitor for compliance implemented safe smol practices by signing cigarent lighters in following and lighters in following 	#58, sidents y. dents ed by what d a nd ensure ocking ters in decting olace or nake to ill e with king acettes	

Event ID: 216H11

<u></u>		T MEDIONID DEITMOLD			7. 0000-00 <u>0</u> 1			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		445278	B, WII	NG_		10/	01/2012	
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BROOK	EWOOD NURSING CE	INTER, INC		ŀ	332 RIVER ROAD DECATUR, TN 37322			
(VA) ID	STIMMADY STA	TEMENT OF DEFICIENCIES	1 15		PROVIDER'S PLAN OF CORREC'	TION	100	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 520	Continued From pa	ge 60	ĺ F	F 520 smoke break to be locked up in				
	with the Administrator, in the conference room,				the medication room(be	ginning	1	
	confirmed the facilit	ed the facility had been made aware of			9/26/12), and with roon	n checks		
		possession of cigarettes this	İ		for contraband. Admini	strative		
:		tember 22 and 23, 2012).			Staff, including the			
	Continued interview confirmed the Licensed Practical Nurse #4 (LPN) had called on Saturday (September 22, 2012) and left a message regarding resident #9 having personal possession of cigarettes. Continued interview confirmed the Administrator told LPN #4 to let the resident keep			İ	Administrator, Business	_		
İ					Manager, Activity Directo	• 1		
					Human Resources, and N	lursing		
}					Supervisors, will do obse	rvation		
	the cigarettes stating	g he/she thought the resident			checks 3x/day, at least 5			
	had been approved	for independent smoking.		Ì	days/week for 4 weeks, t			
		confirmed resident #9 should red to keep cigarettes.			3x/day at leastr2x/ week			
İ		To the thought digital transfer			months, to ensure safe si			
		nber 27, 2012, at 1:05 p.m.,			practices, daily to ensure	•	Į	
		or and the Director of erence room, confirmed the			smoking practices.			
		committee had not identified			•			
	the problem of unsa	fe smoking in order to			How will the corrective action(s) &	je st		
Ì	formulate a plan to a	ddress the problem.			monitored to ensure the alleged			
1	Defer to E272 for fail	lure to complete smoking		- }	deficient practice(s) will not reocc	ur;		
	assessments.	idie to complete smoking			what quality assurance program w	vill be	11/15/12	
		j			put into place?		12,25,	
		lure to update care plans to	•		·		i I	
]	reflect interventions t	for residents safe smoking.		- }	 The Social Services Director 	or,		
	Refer to E323 for fail	ure to supervise and follow		- 1	DON, ADON, and Mainten	ance	1 !	
		ensure safe smoking.			Supervisor will report on t	he	} i	
-		-			compliance monitoring res			
		ure to administer the facility			to the QA Committee mon	-		
		e an effective system was in		ĺ	for 3 months beginning in	•		
	piace to supervise ar smoking.	nd monitor residents for safe			October,			
'								
		ector of Nursing October 1,				ĺ		
2	2012, at 12:50 p.m., 1	revealed members of the			<i>2</i> *		1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		445278	B, WIN	16		10/01	/2012
	ROVIDER OR SUPPLIER	ENTER, INC		33	EET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD ECATUR, TN 37322		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	IULO BE	(X5) COMPLETION DATE
F 520	Administrator, Dire Director of Nursing Activity Director, Br. Medical Records, I Certified Dietary M Supervisor) had more formulate a plan research of the Quantum of the	committee (including the ctor of Nursing, Assistant I, Social Services Director, usiness Office Manager, Maintenance Supervisor, anager, and Housekeeping et on September 28, 2012, to elated to noncompliance with velop a plan to ensure resident interview revealed the utility Assurance committee cility's Smoking Policy, and dents and staff regarding the volicy. Continued interview revices had contacted and e families of the residents who I them of the facility's Smoking interview revealed the facility's ad been made aware of the dy on September 28, 2012. In opardy was effective from 12, through October 1, 2012, and ion of Compliance, which ediacy of the Jeopardy, was ective actions were validated ey team on October 1, 2012, facility documents, staff and and observations. The survey the smoking safety; and residents who smoke at the te smoking assessments was urvey team through	F	520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445278	B. Wil	NG			10/01/	/2012
•	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC	STREET ADDRESS, CITY, STATE, ZIP CO 332 RIVER ROAD DECATUR, TN 37322		ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B E APPROPRIA		(X5) COMPLETION DATE
	2. Verifying reside and #9 had been ed revised smoking po the information on it September 26, 2013 team verified the information of the information on it September 26, 2013 team verified the information of the information	nts #34, #53, #81, #80, #58 lucated on the facility's licy. The survey team verified interview with resident #58 on 2, at 4:00 p.m. The survey cormation with resident #53 and interview on September riew with #80 on September in.m. vision of the facility's smoking redgement of understanding re policy by the residents to ring environment for all the survey team on October 1, terviews with multidisciplinary inservice logs confirmed the reation regarding the facility's ricy including staff members of cigarettes and lighters are up in the medication room, with are collected and placed containers following each rents who are found with rers in their possession will lischarge notice. Review of red the residents and ring residents were notified of	F	520				

Event ID: 216H11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445278	B. WI	NG_		10	104/2042
	PROVIDER OR SUPPLIER EWOOD NURSING CE	NTER, INC	—l , <u>,</u>	STREET ADDRESS, CITY, STATE, ZIP CO. 332 RIVER ROAD DECATUR, TN 37322		10/01/2012 DE	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		JD PREF TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 520	Non compliance monitoring correctiv the facility's Quality Committee.	continues at an "E" level for e actions and evaluation by Assessment and Assurance	F s	520			